

COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

THURSDAY, 26 OCTOBER 2017

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Thursday, 26 October 2017

Members in attendance: Senators Brockman, Jacinta Collins, Dastyari, Di Natale, Duniam, Farrell, Gichuhi, Griff, Kakoschke-Moore, Lines, O'Neill, Polley, Pratt, Roberts, Siewert, Singh, Smith, Watt, Xenophon.

Terms of Reference for the Inquiry:

To inquire into and report on:

HEALTH PORTFOLIO

In Attendance

Senator Nash, Minister for Regional Development, Minister for Local Government and Territories and Minister for Regional Communications

Department of Health

Whole of Portfolio

Ms Glenys Beauchamp PSM, Secretary

Professor Brendan Murphy, Chief Medical Officer

Ms Alison Larkins, Deputy Secretary, Chief Operating Officer Group

Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group

Ms Penny Shakespeare, Acting Deputy Secretary, Health Benefits Group

Dr Lisa Studdert, Acting Deputy Secretary, National Program Delivery Group

Mr Paul Madden, Special Adviser, Strategic Health Systems and Information Management

Dr John Skerritt, Deputy Secretary, Health Products Regulation Group

Ms Catherine Rule, Acting Deputy Secretary, Ageing and Aged Care

Mr Charles Wann, Acting First Assistant Secretary, Portfolio Investment Division

Mr Craig Boyd, Chief Financial Officer, Portfolio Investment Division

Mr Nick Henderson, Chief Budget Officer, Portfolio Investment Division

Ms Rachel Balmanno, First Assistant Secretary, People, Capability and Communication Division

Mr Robert Wright, Assistant Secretary, Ministerial, Parliamentary and FOI Branch, People, Capability and Communication Division

Ms Jodie Grieve, Assistant Secretary, Communication and Change Branch, People, Capability and Communication Division

Ms Donna Moody, First Assistant Secretary, Health State Network

Mr Paul McCormack, Assistant Secretary, Frameworks Branch, Health State Network

Ms Marianne Cullen, First Assistant Secretary, Medicare and Aged Care Payments Division

Mr Garry Fleming, Principal Adviser, Corporate Strategy Unit

Ms Jackie Davis, First Assistant Secretary, Legal Division

Mr Daniel McCabe, First Assistant Secretary, Information Technology Division

Ms Maria Jolly, First Assistant Secretary, Health Systems Policy Division

Mr Matt Williams, Assistant Secretary, International Strategies Branch, Health Systems Policy Division

Outcome 1

Dr Nick Hartland, First Assistant Secretary, Research Data and Evaluation Division

Ms Erica Kneipp, Assistant Secretary, Health and Medical Research Branch, Research Data and Evaluation Division

Ms Nicole Jarvis, Assistant Secretary, Digital Health Branch, Health Systems Policy Division

Ms Marianne Cullen, First Assistant Secretary, Medicare and Aged Care Payments Division

Mr Tim Kelsey, Chief Executive Officer, Australian Digital Health Agency

Mr Ronan O'Connor, Executive General Manager, Core Services Systems Operations Division, Australian Digital Health Agency

Mr Terence Seymour, Executive General Manager, Organisational Capability and Change Management Division, Australian Digital Health Agency

Ms Bettina McMahon, Executive General Manager, Government and Industry Collaboration, Strategy and Delivery Division, Australian Digital Health Agency

Mr David Delaporte, General Manager, Organisational Capability and Change Management Division, Australian Digital Health Agency

Mr Mark Kinsela, Chief of Staff, Office of the CEO, Australian Digital Health Agency

Mr Anthony Kitzelmann, General Manager, Core Services Systems Operations, Australian Digital Health Agency

Mr Garth McDonald, General Manager, Core Services Systems Operations, Australian Digital Health Agency

Outcome 2

Mr Jaye Smith, First Assistant Secretary, Population Health and Sport Division

Ms Elizabeth Flynn, Assistant Secretary, Preventive Health Policy Branch, Population Health and Sport Division

Ms Alice Creelman, Assistant Secretary, Cancer and Palliative Care Branch, Population Health and Sport Division

Mr David Laffan, Assistant Secretary, Drug Strategy Branch, Population Health and Sport Division

Mr George Masri, Assistant Secretary, Tobacco Control Branch, Population Health and Sport Division

Mr David Paull, Acting First Assistant Secretary, National Cancer Screening Program Division

Ms Bobbi Campbell, First Assistant Secretary, Indigenous Health Division

Mr David Hallinan, First Assistant Secretary, Health Workforce Division

Ms Chris Jeacle, Assistant Secretary, Rural Access Branch, Health Workforce Division

Ms Fay Holden, Assistant Secretary, Health Training Branch, Health Workforce Division

Ms Lynne Gillam, Assistant Secretary, Health Workforce Reform Branch, Health Workforce Division

Ms Maria Jolly, First Assistant Secretary, Health Systems Policy Division

Ms Janet Quigley, Assistant Secretary, Primary Health Care Reform and Implementation Branch, Health Systems Policy Division

Mr Shane Porter, Assistant Secretary, Strategic Policy Branch, Health Systems Policy Division

Mr Ben Noyen, Assistant Secretary, Portfolio Strategies, Engagement and Coordination Branch, Health Systems Policy Division

Dr Nick Hartland, First Assistant Secretary, Research Data and Evaluation Division

Mr Shannon White, Assistant Secretary, Health System Financing Branch, Research Data and Evaluation Division

Ms Natasha Cole, First Assistant Secretary, Health Services Division

Mr Mark Booth, Chief Executive Officer, Food Standards Australia New Zealand

Mr Peter May, General Manager, Corporate Services, Food Standards Australia New Zealand

Dr Scott Crerar, General Manager, Science and Risk Assessment, Food Standards Australia New Zealand

Dr Nick Fletcher, Section Manager, Risk Assessment Chemical Safety and Nutrition, Food Standards Australia New Zealand

Dr Peggy Brown, Chief Executive Officer, National Mental Health Commission

Mr James Downie, Chief Executive Officer, Independent Hospital Pricing Authority

Outcome 3

Mr Jaye Smith, First Assistant Secretary, Population Health and Sport Division

Mr Andrew Godkin, Sports Integrity Adviser, National Integrity of Sport Unit, Population Health and Sport Division

Ms Narelle Smith, Assistant Secretary, Office for Sport, Population Health and Sport Division

Mr David Sharpe, Chief Executive Officer, Australian Sports Anti-Doping Authority

Ms Judith Lind, National Manager, Operations, Australian Sports Anti-Doping Authority

Mr Darren Mullaly, Acting National Manager, Legal and Support Services, Australian Sports Anti-Doping Authority

Ms Kate Palmer, Chief Executive Officer, Australian Sports Commission

Mr Peter Conde, Director, Australian Institute of Sport

Mr Robert Medlicott, Acting Director, Australian Institute of Sport

Mr Geoff Howes, Acting General Manager, Participation and Sustainable Sports, Australian Sports Commission

Ms Carolyn Brassil, General Manager, Corporate Operations, Australian Sports Commission

Ms Fiona Johnstone, Chief Financial Officer, Corporate Operations Division, Australian Sports Commission

Outcome 4

Mr David Weiss, First Assistant Secretary, Medical Benefits Division

Mr Andrew Simpson, Assistant Secretary, Medicare Reviews Unit, Medical Benefits Division

Ms Trisha Garrett, Assistant Secretary, Hearing and Diagnostic Imaging Services, Medical Benefits Division

Ms Natasha Ryan, Assistant Secretary, MBS Policy and Specialist Services Branch, Medical Benefits Division

Ms Celia Street, Assistant Secretary, Primary Care, Analytics and Pathology Branch, Medical Benefits Division

Mr Jack Quinane, Director, Pathology Services Section, Primary Care, Analytics and Pathology Branch, Medical Benefits Division

Ms Ann Smith, First Assistant Secretary, Technology Assessment and Access Division

Ms Julianne Quaine, Assistant Secretary, Pharmacy and Insurance Branch, Technology Assessment and Access Division

Ms Lisa La Rance, Assistant Secretary, Policy and Pricing Branch, Technology Assessment and Access Division

Ms Louise Clarke, Assistant Secretary, Office of Health Technology Assessment Policy Branch, Technology Assessment and Access Division

Dr Megan Keaney, Acting Assistant Secretary, Office of Health Technology Assessment Policy Branch, Technology Assessment and Access Division

Mr Simon Cotterell, First Assistant Secretary, Provider Benefits Integrity Division

Ms Maria Jolly, First Assistant Secretary, Health Systems Policy Division

Mr Charles Maskell-Knight, Principal Adviser, Private Health Insurance Taskforce, Health Systems Policy Division

Mr Matt Williams, Assistant Secretary, International Strategies Branch, Health Systems Policy Division

Outcome 5

Ms Sharon Appleyard, First Assistant Secretary, Office of Health Protection

Dr Gary Lum AM, Principal Medical Adviser, Office of Health Protection

Dr Jenny Firman, Principal Medical Adviser, Office of Health Protection

Ms Rhonda Owen, Assistant Secretary, Health Emergency Management Branch, Office of Health Protection

Ms Sarah Norris, Assistant Secretary, Health Protection Policy Branch, Office of Health Protection

Dr Masha Somi, Assistant Secretary, Immunisation Branch, Office of Health Protection

Dr Tim Greenaway, Chief Medical Adviser, Health Products Regulation Group

Ms Kerrie-Anne Luscombe, Principal Legal and Policy Adviser, Health Products Regulation Group

Ms Adriana Platona, First Assistant Secretary, Medical Devices and Product Quality Division, Health Products Regulation Group

Mr Ross Hawkins, First Assistant Secretary, Regulatory Practice and Support Division, Health Products Regulation Group

Mr Bill Turner, Assistant Secretary, Office of Drug Control, Health Products Regulation Group

Ms Maria Jolly, First Assistant Secretary, Health Systems Policy Division

Ms Gillian Shaw, Assistant Secretary, Best Practice Regulation Branch, Health Systems Policy Division

Dr Raj Bhula, Gene Technology Regulator, Office of the Gene Technology Regulator

Mr Neil Ellis, Acting Assistant Secretary, Office of the Gene Technology Regulator

Outcome 6

Ms Debra Thoms, First Assistant Secretary, Ageing and Aged Care Services Division and Chief Nursing and Midwifery Officer

Mr Michael Culhane, First Assistant Secretary, Aged Care Policy and Regulation Division

Ms Fiona Buffinton, First Assistant Secretary, Aged Care Access and Quality Division

Mr Nigel Murray, Assistant Secretary, Funding Policy Branch, Aged Care Policy and Regulation Division

Ms Valerie Spencer, Acting Assistant Secretary, Prudential and Approved Provider Regulation Branch

Ms Amy Laffan, Assistant Secretary, Quality Reform Branch, Aged Care Access and Quality Division

Mr Travis Haslam, Assistant Secretary, Access Policy and Performance Branch, Aged Care Access and Quality Division

Mr Nick Ryan, Chief Executive Officer, Australian Aged Care Quality Agency

Ms Rae Lamb, Australian Aged Care Complaints Commissioner

Committee met at 08:59

CHAIR (Senator Brockman): I declare open this meeting of the Senate Community Affairs Legislation Committee. The Senate has referred to the committee the particulars of proposed expenditure for 2017-18 for the portfolios of Health and Social Services, including Human Services. The committee may also examine the annual reports of the departments and agencies appearing before it. The committee has fixed 6 December 2017 as the date for the return of answers to questions taken on notice. Senators are reminded that any written questions on notice should be provided to the committee secretariat by 3 November 2017. The committee's proceedings today will begin with its examination of the Health portfolio, commencing with cross-portfolio and corporate matters. The committee will then continue with the Department of Health and other portfolio agencies as listed on the program.

Under standing order 26, the committee must take all evidence in public session. This includes answers to questions on notice. I remind all witnesses that, in giving evidence to the committee, they are protected by parliamentary privilege. It is unlawful for anyone to threaten

or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee. The Senate, by resolution in 1999, endorsed the following test of relevance of questions at estimates hearings: any question going to the operations or financial positions of the departments and agencies which are seeking funds in the estimates are relevant questions for the purpose of estimates hearings. I remind officers that the Senate has resolved that there are no areas in connection with the expenditure of public funds where any person has a discretion to withhold details or explanations from the parliament or its committees unless the parliament has expressly provided otherwise.

The Senate has resolved also that an officer of a department of the Commonwealth shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. I particularly draw the attention of witnesses to an order of the Senate of 13 May 2009, specifying the process by which a claim of public interest immunity should be raised.

The extract read as follows—

Public interest immunity claims

That the Senate—

(a) notes that ministers and officers have continued to refuse to provide information to Senate committees without properly raising claims of public interest immunity as required by past resolutions of the Senate;

(b) reaffirms the principles of past resolutions of the Senate by this order, to provide ministers and officers with guidance as to the proper process for raising public interest immunity claims and to consolidate those past resolutions of the Senate;

(c) orders that the following operate as an order of continuing effect:

(1) If:

(a) a Senate committee, or a senator in the course of proceedings of a committee, requests information or a document from a Commonwealth department or agency; and

(b) an officer of the department or agency to whom the request is directed believes that it may not be in the public interest to disclose the information or document to the committee, the officer shall state to the committee the ground on which the officer believes that it may not be in the public interest to disclose the information or document to the committee, and specify the harm to the public interest that could result from the disclosure of the information or document.

(2) If, after receiving the officer's statement under paragraph (1), the committee or the senator requests the officer to refer the question of the disclosure of the information or document to a responsible minister, the officer shall refer that question to the minister.

(3) If a minister, on a reference by an officer under paragraph (2), concludes that it would not be in the public interest to disclose the information or document to the committee, the minister shall provide to the committee a statement of the ground for that conclusion, specifying the harm to the public interest that could result from the disclosure of the information or document.

(4) A minister, in a statement under paragraph (3), shall indicate whether the harm to the public interest that could result from the disclosure of the information or document to the committee could result only from the publication of the information or document by the committee, or could result,

equally or in part, from the disclosure of the information or document to the committee as in camera evidence.

(5) If, after considering a statement by a minister provided under paragraph (3), the committee concludes that the statement does not sufficiently justify the withholding of the information or document from the committee, the committee shall report the matter to the Senate.

(6) A decision by a committee not to report a matter to the Senate under paragraph (5) does not prevent a senator from raising the matter in the Senate in accordance with other procedures of the Senate.

(7) A statement that information or a document is not published, or is confidential, or consists of advice to, or internal deliberations of, government, in the absence of specification of the harm to the public interest that could result from the disclosure of the information or document, is not a statement that meets the requirements of paragraph (1) or (4).

(8) If a minister concludes that a statement under paragraph (3) should more appropriately be made by the head of an agency, by reason of the independence of that agency from ministerial direction or control, the minister shall inform the committee of that conclusion and the reason for that conclusion, and shall refer the matter to the head of the agency, who shall then be required to provide a statement in accordance with paragraph (3).

(d) requires the Procedure Committee to review the operation of this order and report to the Senate by 20 August 2009.

(13 May 2009 J.1941)

(Extract, Senate Standing Orders)

Witnesses are specifically reminded that a statement that information or a document is confidential or consists of advice to government is not a statement that meets the requirements of the 2009 order. Instead, witnesses are required to provide some specific indication of the harm to the public interest that could result from the disclosure of the information or the document.

Department of Health

[09:02]

CHAIR: I welcome Senator the Hon. Fiona Nash, Minister for Regional Development, Minister for Local Government and Territories and Minister for Regional Communications representing the Minister for Health, and officers of the Department of Health. Minister, do you wish to make an opening statement?

Senator Nash: No thank you, Chair, except to welcome Ms Beauchamp, as the new secretary, to her first estimates with us.

CHAIR: Yes, welcome.

Senator SINGH: Good morning. Ms Beauchamp. I want to begin by getting an update on the number of reviews and other activities that are underway.

Ms Beauchamp: That's a very broad-ranging question. Obviously there's a big reform agenda the department and portfolio are progressing on behalf of the government, and you would expect a number of reviews to be taking place across our keys areas of operation. I haven't a consolidated list of reviews, but, if there's a particular area you'd like to focus on, I'm happy to take that, or take the question on notice.

Senator SINGH: You don't have a list?

Ms Beauchamp: I haven't got a consolidated list, but I'm aware of many, many reviews.

Senator SINGH: Let's pick away at it a bit. I understand the government is doing a review of MRI licences.

Ms Beauchamp: MRI licences, yes.

Senator SINGH: Where is that one up to?

Ms Beauchamp: Are we looking at cross-portfolio issues here?

Senator SINGH: We are. We are in cross-portfolio at the moment.

Ms Beauchamp: I'll have to get the key officers to come to the table. Hopefully, they're here.

Mr Weiss: Are you talking about a review of MRI? I'm aware of a Senate inquiry that's underway into diagnostic engine equipment which would include MRI.

Senator SINGH: No, I'm talking about a review of MRI licences. To refresh your memory, in September the minister's office told the *Caboolture Herald* that 'The minister has requested a review into the provision of MRI licences across the country.' It was on 7 September.

Mr Weiss: Okay.

Senator SINGH: So you know nothing about that?

Mr Weiss: We're doing some work on that. MRI licences are approved by the government. They're approved periodically. The minister has asked us to do some work to inform consideration of an expansion of the number of MRI licences, but, to this point, it's work that it is internal to the department. It hasn't gone further than that.

Senator SINGH: I'm actually talking about a review that the minister has requested, and this seems to be something the department doesn't know anything about.

Mr Weiss: As I said, we are doing some work to inform consideration of a possible expansion of the number of MRI licences, but it's not a review in the sense that we're out there publicly consulting on it or anything at this stage.

Senator SINGH: Can I just get this clear: as far as the department is concerned, there is no review going on into MRI licences?

Ms Shakespeare: I think that's not what Mr Weiss said. We're doing internal work on MRI licences and there is certainly an external review underway at the moment through a Senate inquiry.

Senator SINGH: All right. Let's talk about the work on the transparency model into IVF success rates. When can we see that introduced?

Ms Shakespeare: The department has been working with the Fertility Society of Australia and with the Australia and New Zealand Assisted Reproduction Database to see whether there is any possibility to link the dataset with publicly-available information under the MBS. MBS data does not actually provide outcomes in terms of successful live births. But there is some data available, and the department is considering how that information could be linked.

Senator SINGH: Is that the transparency model that the government is investigating that it wants to introduce? Is that what you have just outlined to me?

Ms Shakespeare: I'm not sure what you mean by 'the transparency model'. There's also some separate work happening through the MBS taskforce around fees and charges for the way that IVF doctors are billing Medicare services. Is that what you mean?

Senator SINGH: I guess I'm asking you what the transparency model is. Are you aware that the government is investigating introducing a transparency model?

Ms Shakespeare: We're doing a range of work around IVF. If you could indicate which particular piece of work you are interested in, that would be of assistance.

Senator SINGH: Can I just quote you *The Daily Telegraph* on 13 September:

The government is currently investigating introducing a "transparency model" to improve patients' knowledge about treating doctors' success and failures across a range of specialties.

I just want to know what this transparency model is.

CHAIR: To assist the witness, do you have the article there that you could table, Senator Singh?

Senator SINGH: I could if she'd like.

CHAIR: I'm happy to give a little bit of latitude here, but, if we're going to get too far into the weeds on these issues, I'm happy for it to be referred to the correct section of the program.

Senator SINGH: I'm happy to move on. I just wanted answers to some questions—that's all.

CHAIR: But we are getting into some detail here.

Senator SINGH: Yes. I'm just asking what the transparency model is and where it's at. That's all. And then we can move on. It seems the department isn't sure what I mean. That is the answer I got, so I quoted the article.

Mr Weiss: I haven't heard anything referred to by the title 'transparency initiative', so I think that's what's throwing us a little bit. We're aware that there was some media coverage in September of employment arrangements in IVF clinics and, in response to that, we're aware that the minister did ask the MBS Review Taskforce to investigate the matter.

Senator SINGH: All right. It seems that the minister's saying one thing and not letting the department know, perhaps. Can I ask about the full medical—

Senator Nash: That's an assumption on your part, Senator.

Senator DASTYARI: Let's just keep moving, guys. It's ten past nine.

Senator SINGH: Can I ask about the full medical review of Lyme disease. What is happening with this?

Prof. Murphy: Are you referring to the government response to the Senate inquiry on Lyme disease?

Senator SINGH: I'm referring to a statement in June to *The Northern Star* that said:
... the Minister believes that families deserve a full medical review and analysis—
of Lyme disease.

Prof. Murphy: The government's response to the Senate inquiry is ready for tabling and should be tabled at the next available opportunity when the Senate sits, and in that the government will outline a range of responses to that inquiry, including those matters that

you're talking about. That will include working with the jurisdictions to develop multidisciplinary clinic models to fully assess people with these symptom complexes. But I wouldn't want to pre-empt the government response to the inquiry until it's tabled at the next available sitting of the Senate.

Senator SINGH: All right. I understand there's additional research into the Buruli ulcer. Can you provide an update on this?

Prof. Murphy: Yes. Buruli ulcer is a very unusual infection with a mycobacterium. In Australia, it's intensely localised to some small areas. It's essentially only in Victoria and some tiny areas in Queensland, but in Victoria it's been geographically localised—initially in Bairnsdale and then in the Bellarine Peninsula, and now it's spread across to the Mornington Peninsula. We know what the organism is, and we know how to treat it. The challenge is one of early diagnosis and trying to understand the pathogenesis—where the bacterium lives in the environment and how humans are infected. We've been working with the Victorian Department of Health and Human Services, who have primary responsibility for a Victorian public health issue. They've invested some money in some fieldwork in the Mornington Peninsula and a program to educate general practitioners in early diagnosis. I've been working with three research groups in Melbourne, and they're putting together an NHMRC partnership grant, which is about to be submitted and supported by the Victorian government. We hope that that will be successfully received. If not, we will work further with the Victorian government to see what support we can do for research, because the environment we have now, where one part of Port Phillip Bay has a declining incidence and the other has an increased incidence, provides a unique opportunity to try and understand where this organism lives and how to work it through. So we're working very closely with Victoria, which has the primary response.

Senator SINGH: Can I just take you back: when you talked about the review of Lyme disease and said you're waiting for the inquiry outcome, will that be a full medical review?

Prof. Murphy: There will be a range of options outlined in that response. I think one of the tenets of the department's position is that people with these terrible symptom complexes need a broad based medical assessment which doesn't assume a particular aetiology of their symptoms. I really don't think it's appropriate that I pre-empt it. It's the government's prerogative to outline its response, and I'm not sure it's appropriate for me to go into the detail of that.

Senator SINGH: I want to ask now about the minister's undertaking that a vaccine for the A, C, Y and W strains of meningococcal will be listed on the National Immunisation Program. When will this happen?

Prof. Murphy: We're working very closely at the moment with the relevant sponsors of those agents. As the minister said, he's very hopeful that we will have that on the National Immunisation Program for next year's meningococcal season. We're working through the regulatory and PBAC processes to fast-track a review of that, so we can't make any definitive announcements about it until probably early next year, but we're confident that progress is good in that regard.

Senator SINGH: What pharmaceutical companies are the department in discussion with?

Prof. Murphy: I'm not sure that's appropriate for me to disclose, because there are three sponsors who have that vaccine. All of them may or may not have an interest in providing the vaccine.

Senator SINGH: What can you give as an expected date for the listing?

Prof. Murphy: I would anticipate, if all goes well, that we should be able to make some sort of announcement in February or thereabouts next year.

Senator SINGH: So the announcement in February would be for—

Prof. Murphy: For the National Immunisation Program for the meningococcal season, which generally takes place in the second half of the year. We're in the later stages of it at the moment.

Senator DI NATALE: Can I quickly go to the mycobacterium ulcerans again? You're aware of the spike in cases. I'm not sure if you're aware of Ella Croft's petition to Minister Hunt, with 15,000 signatures?

Prof. Murphy: I am, yes.

Senator DI NATALE: You mentioned that there was an NHMRC grant being put together. Is that correct?

Prof. Murphy: Yes.

Senator DI NATALE: And that's a consortium of Barwon Health and—

Prof. Murphy: Barwon Health, Doherty and Austin Health—all three research grants.

Senator DI NATALE: Have you got any sense of the timing on that?

Prof. Murphy: That's being submitted in early December.

Senator DI NATALE: Early December.

Prof. Murphy: And I think that then it will go through the consideration process.

Senator DI NATALE: You mentioned the Victorian government. It's not a national—

Prof. Murphy: Well, the buruli ulcer issue is very much a focal Victorian public health issue.

Senator DI NATALE: Aren't there pockets in Queensland as well?

Prof. Murphy: Very tiny pockets—almost insignificant.

Senator DI NATALE: I've probably got it!

Prof. Murphy: It's been almost dormant in those areas. The challenge for us and the research opportunities are definitely in Victoria.

Senator DI NATALE: If the Victorian government don't stump up—

Prof. Murphy: They have offered to support the partnership grant.

Senator DI NATALE: Right.

Prof. Murphy: That's a new development. We will be watching this very closely. Minister Hunt is very concerned to make sure that this research is done, so we'll be working with the Victorian government and see what happens with the NHMRC process.

Senator DI NATALE: They've already committed to you that they're committed to supporting an NHMRC partnership—

Prof. Murphy: A partnership grant, yes,

Senator DI NATALE: They have. Okay, that's good. Do you have any awareness as to why the increase in cases is being reported at the moment—any sense of what's going on?

Prof. Murphy: I think that's one of the great medical research mysteries. This disease is really unusual. We think the hosts are possums, probably. We're not sure how it gets from the possums to the human skin. Mosquitos have been one postulate, but we need to determine in this research whether the possums in the Bellarine Peninsula now have less of the bug. It's certainly been detected in the possums in the Mornington Peninsula, but why one group of possums in a very tightly-localised area would have it and not in another areas is really unknown.

The disease exists in Africa, where it's not so geographically localised, and it's very much a disease of poor social conditions. We don't know what the host is there. So it's an unusual and strange disease, and we definitely have an opportunity now to do some serious research into the transmission and spread.

Senator DI NATALE: That's encouraging, and I look forward to seeing some of that research funded. I want to ask a couple of questions about medicinal cannabis while we're here. Ms Beauchamp, are you aware of the Medicinal Cannabis Legislation Amendment (Securing Patient Access) Bill 2017 that was passed in the Senate last Thursday?

Ms Beauchamp: Yes.

Senator DI NATALE: Are you aware about what it actually does?

Ms Beauchamp: In terms of the detail, I'll be looking to my right hand here, Dr Skerritt.

Dr Skerritt: It's generally not practice for officials to comment on bills before parliament. Is your question just about the scope of the bill or—

Senator DI NATALE: Well, given that it's my bill, I'm aware of the scope of it!

Dr Skerritt: I thought you may be!

Senator DI NATALE: I'm interested in the response to it more than the scope of it.

Dr Skerritt: Again, I would defer to the chair, but it is not usual practice for an official to comment on the merits or otherwise of a bill. This is a bill still before parliament. It may have passed the Senate but it has not yet entered the House.

CHAIR: That's correct.

Senator DI NATALE: Do you have any plans to allow special access scheme category A access to medicinal cannabis? Are there any plans afoot?

Dr Skerritt: Following the successful disallowance in June, we do permit special access scheme A. People can apply and products can be imported for their use.

Senator DI NATALE: Are you continuing to write to importers to say that it's a breach of their licence if they do so?

Dr Skerritt: No. The licence granted to those imports was at a time when the licence was conditioned that the product required an approval. That's for licences—and permits, actually, to be more specific—under which those products were imported at that point in time. So the conditions of those licences hold. We have not had new applications for bulk imports, but we have had applications for imports for patients under special access scheme. We have not

written to those importers, because they're free to import under special access scheme following the disallowance.

Senator DI NATALE: So, just to be clear about this: you granted particular licence conditions for a group of people, and that included restrictions—

Dr Skerritt: No, they were for a group of products imported under the Customs (Prohibited Imports) Regulations. Under those regulations, whether you're importing a television set or a refrigerator, there are conditions of import of a product.

Senator DI NATALE: But those conditions were in place before the disallowance motion was put in place—correct?

Dr Skerritt: Correct.

Senator DI NATALE: And now that the disallowance motion has successfully passed the Senate, do you have any plan to revisit the conditions that existed on those previous—

Dr Skerritt: The conditions for those—

Senator DI NATALE: To give effect to the legislation or the regulation that passed the Senate.

Dr Skerritt: It would require the legislation to pass the parliament and to receive royal assent.

Senator DI NATALE: Well, let me be more specific. To give effect to the disallowance motion that passed the Senate, do you intend to revisit the conditions on the people who had previously been issued permits?

Dr Skerritt: I think there's some confusion in law here. The disallowance motion was a disallowance of conditions that related to imported product from a time forward. Our legal advice is that based on the disallowance motion of June we do not have to go back and change the conditions on import permits for products that have already been imported into the country. That is not the normal practice in any form of importing—to retrospectively change the import conditions on a licence.

Senator DI NATALE: So will those people who have been given a licence be able to import according to the disallowance motion that passed the Senate?

Dr Skerritt: They will be able to make subsequent imports on subsequent permits. Every permit is considered on a case-by-case basis, but there should be no reason, subject to the requirements of the permit, that patients should not be able to get access under category A. As I've said, subsequent to the disallowance, there has not been a large number but there have been permits granted for patients to receive products under category A.

Senator SINGH: Could you say how many?

Dr Skerritt: We've only had five notifications of category A since the disallowance in June. I understand there may only have been one permit application—and that was granted.

Senator DI NATALE: You wrote, though, to the people who held pre-existing licences saying that the disallowance would not change the conditions of the permits they were issued; is that correct?

Dr Skerritt: One of my officials wrote to them because that is actually the correct situation in law. These were pre-existing permits granted under conditions as they were at the time of importation.

Senator DI NATALE: Are you saying each of those individuals you wrote to are now free to import medicinal cannabis products?

Dr Skerritt: Each import requires a permit. So a licence checks the overarching system. Permits are granted on an import-by-import basis. For future permits, they can come to us.

Senator DI NATALE: So why did you write to them to say that their conditions restricted them from doing that?

Dr Skerritt: To remind them that the stock that they have already imported was imported under the conditions that were extant at the time.

Senator DI NATALE: So you're saying that that is purely about the existing stock and that each of those existing licence holders can now import medicinal cannabis under the Special Access Scheme category A?

Dr Skerritt: No, I did not say that. Remember the importation is actually not under the special access scheme A. It is under the Customs—

Senator DI NATALE: Yes, it is a semantic difference.

Dr Skerritt: No, these are two different sets of regulations administered under different acts that are administered in different portfolios, although we do administer the Customs (Prohibited Imports) Regulations on behalf of the relevant department. There's a difference between what may apply to imports that have already been made. This is the same with any import of a product. You get a permit for a particular lot of product that is imported at a point in time. They were the conditions at that point of time. If the same companies apply for subsequent imports then that will be considered on its merits and on the situation at the time.

Senator DI NATALE: And what are its merits?

Dr Skerritt: You look at the requirements for the patient group, you look at the security requirements the company have and you look to check that the product is actually appropriate. Why is there this level of scrutiny? It is because these substances are specified in Customs regulations—

Senator DI NATALE: Just to be clear, to the people you wrote to you said: 'For the product you have already imported, you can't. But if you are to import any further product and it is for the purposes of Special Access Scheme category A you will not be breaching your licence conditions.'

Dr Skerritt: No, we did not put the second thing in the letter. We were silent on that issue. The letter we wrote was—

Senator DI NATALE: That's why I'm asking you to clarify it.

Dr Skerritt: I believe I have clarified it.

Senator DI NATALE: I'm asking, just to be very clear, if somebody has a licence and they were from this point on to import medicinal cannabis and it was to be made available to a patient under Special Access Scheme category A they would not be in breach of their licence conditions?

Dr Skerritt: They would need a new permit. As I said before, for every permit for every substance imported under the Customs (Prohibited Imports) Regulations, the situation is looked at on a case-by-case basis. But certainly there is no intention for a blanket—

Senator DI NATALE: 'Case-by-case basis'—what does that mean? If they've got a letter from their doctor that satisfies category A, can they import it or not?

Dr Skerritt: The individuals are not importing these substances. They are generally imported by companies that have skills in bringing pharmaceuticals into the country. For pharmaceuticals that are otherwise prohibited imports—

Senator DI NATALE: I understand that.

Dr Skerritt: a licence and a permit is required.

Senator DI NATALE: If you have a terminal illness, you want to know whether you can get access to medicinal cannabis under Special Access Scheme category A from someone who can import the product under a particular set of conditions. You just want to know you can get access to the drug. What I'm saying to you is that you wrote to those people who have existing licences at the moment saying, 'You can't make this product that you've imported available to patients under the Special Access Scheme,' despite the Senate having said we think they should. Are you now saying that, if they were to import further product and it satisfied the conditions of Special Access Scheme category A, they would be able to do it and they wouldn't be breaching their licence conditions?

Dr Skerritt: If it satisfied the other conditions of security, of product quality—so there are a whole lot of issues that you look at when you import—

Senator DI NATALE: I know, but you've already given them licences to do that.

Dr Skerritt: No, there's a licence and a permit. This is on a permit for an individual importation of a product. But I cannot see any reason, if they meet those criteria, that a permit application would be rejected.

Senator DI NATALE: Thank you. I think we're there. Can you just tell me the total number of medicinal cannabis prescriptions that have been approved through the Special Access Scheme?

Dr Skerritt: The total number of Special Access Scheme approvals is 213, and there are a further 101 at least as of 30 June under authorised prescriber.

Senator DI NATALE: How do the 213 compare to when we spoke last time?

Dr Skerritt: I don't have a comparative figure, but I believe there's about an additional 60 or 70 or so. But I would have to take that on notice.

Senator DI NATALE: I think that broadly tallies with my recollection of where we were last time. So, since May, we think there have been an additional 60.

Dr Skerritt: I would have to take the exact figure on notice. I have figures in front of me from January 2016. There's certainly been, in 2017, a significant increase in the amount of Special Access Scheme patient access to medicinal cannabis.

Senator DI NATALE: You consider 213 to be significant when we're talking about—

Dr Skerritt: No, I talked about since the initial scheme. I said there's a significant increase in 2017 compared with 2016.

Senator DI NATALE: An increase from what? Zero?

Dr Skerritt: No, there were Special Access Scheme approvals granted going back a decade or more, but in very small numbers—one, two or three a year.

Senator DI NATALE: Yes, close to zero. So you're saying you feel like 213 over the course of a year is a significant increase?

Dr Skerritt: It's a significant increase from 2016. That's what I said.

Senator DI NATALE: Where the numbers were in the—

Dr Skerritt: Well, back in 2016 we were probably sitting at about 100 or so, but again I'd take those figures on notice.

Senator DI NATALE: Just so that I understand what you mean by 'significant', we're talking in the ballpark of 100?

Dr Skerritt: Well, it's a doubling. Doubling is significant.

Senator DI NATALE: Would a doubling from one to two be significant?

Dr Skerritt: Proportionally it is, but we're going from 100 to 213—

Senator DI NATALE: Not when you're talking about tens of thousands.

Dr Skerritt: plus 101.

Senator DI NATALE: So, just as a ballpark—

Dr Skerritt: That's a significant increase in numbers.

Senator DI NATALE: we've gone from 100, roughly, in 2016 to 213 in 2017, yes?

Dr Skerritt: Two hundred and thirteen SAS and 101 to 30 June. We don't know whether there are another 50 or 100 authorised prescriber prescriptions. We won't get that figure until after Christmas.

Senator DI NATALE: I think most people wouldn't see that as significant. They'd see it as incredibly slow and frustrating progress.

Senator SINGH: Nor would they see it as being what you said, Dr Skerritt, last time in estimates, when you cited a university study that 30,000 Australians could benefit from medicinal cannabis. I remember Senator Di Natale and you had a bit of a barney about that study. I don't want to go into that now, but I think we can agree that the number of Australians who are accessing medicinal cannabis is tens of thousands short of that.

Dr Skerritt: With respect, I think there's a fundamental misunderstanding of the role of TGA here from senators. We respond to applications received from doctors. We have had a very significant program—at least within the resources available—of education information to doctors in a range of capital cities over the last few months. But, at the end of the day, it's up to the doctor to write the prescription, whether it's category A or category B. We do not write prescriptions. We are the regulator. We have not rejected a single application from a doctor, but the pen is in the hands of the doctors here.

Senator DI NATALE: You have not rejected a single application from a doctor?

Dr Skerritt: We have not rejected a single application from a doctor.

Senator DI NATALE: What's the longest it's taken for you to approve an application?

Dr Skerritt: I would have to take the longest on notice. The time with us averages between two and three days. There are times, as we've discussed before in this place, where a doctor might write 'medicinal cannabis', and the laws require us to specify a particular product and a specific dose, so we go back to the doctor. They may take overnight to come back to us; they may take six months. That period is out of our control even when we give them reminders.

Senator DI NATALE: Can I just ask you about whether you're aware of cases in Queensland where a Special Access Scheme category B application has taken over a year as a result of delays?

Dr Skerritt: There is a case where an individual, again, was not able to get the appropriate approvals from Queensland and their doctor took a year to submit the clinically required information.

Senator DI NATALE: You're saying it was the doctor who didn't supply the—

Dr Skerritt: Yes—correct.

Senator DI NATALE: What sort of information didn't they supply?

Dr Skerritt: Again, I don't want to talk too much about an individual's case, so I'll talk in general terms. Even though I know the name of the individual, I won't give it. This was a case where it was for a particular sort of cancer that there wasn't much information, if any, on the role of medicinal cannabis in treating that cancer. So both the Queensland department—and they were the main interlocutors—and our people said, 'Can you send a bit more information about what's been tried with the patient and the case for that?' This was a case where it was a most unusual potential application for medicinal cannabis. And that's why it was back with the doctor for quite a long period.

Senator DI NATALE: Just to be clear, this is somebody who's got cancer where an application for medicinal cannabis is made and it takes them over a year to access the drug.

Dr Skerritt: Well, that's really, again, in the hands of their doctor.

Senator DI NATALE: Well, no, because the doctor applied for medicinal cannabis and there were delays of well over a year before the drug was accessed.

Dr Skerritt: The delays were with the doctor.

Senator DI NATALE: If you're the person who's sitting there with the terminal cancer and you are going to benefit from this drug—

Dr Skerritt: Again, I don't want to talk too much about an individual patient, but this is not a terminal cancer.

Senator DI NATALE: You've got somebody who has a—

Dr Skerritt: It's a type of malignancy, but, again, I don't think it's appropriate to talk about the clinical details.

CHAIR: I've allowed a lot of latitude. We're really getting into the weeds here.

Senator DI NATALE: I just have a couple of very quick questions and then I'm done.

CHAIR: Two more questions.

Senator DI NATALE: Yes. Is the TGA aware that in New South Wales, Tassie and Queensland GPs aren't unable to prescribe?

Dr Skerritt: Sorry, Senator.

Senator DI NATALE: Is the TGA aware that in New South Wales, Tassie and Queensland GPs can't actually prescribe medicinal cannabis? Is that right?

Dr Skerritt: It's not as black and white as that. There are particular pathways where GPs can prescribe, but, generally, under the overarching supervision of a specialist. These are matters—

Senator DI NATALE: That's right. That doesn't happen—

Dr Skerritt: Senator, sorry; if I can finish my response. These are matters of state law which the Commonwealth does not control. The minister has written to every state and territory health minister encouraging them to work with their health departments on streamlining and aligning the frameworks as much as possible. But, at the end of the day, as ever as it has been in Federation, these are issues to do with the state and territory governments and their sovereign decisions to put in whatever conditions they wish for access to schedule 8 medicines in particular.

Senator DI NATALE: What's the total number of authorised prescribers so far?

Dr Skerritt: There are 29 authorised prescribers.

Senator DI NATALE: So, basically, if you're a GP in Queensland and you're not working with a specialist, you can't prescribe—the same as New South Wales and the same as Tassie—and there are 29 authorised prescribers nationally. What's the breakdown?

Dr Skerritt: I think we need to categorise what we mean by 'authorised prescribers'.

Senator DI NATALE: What's the breakdown of authorised prescribers.

Dr Skerritt: Sorry, Senator—

Senator DI NATALE: I'm conscious of time.

Dr Skerritt: On the record, I think it's important to define what 'authorised prescriber' means. There are many more than 29 doctors in this country who been approved to prescribe medicinal cannabis. There are well over 100. Authorised prescribers is when—again, it's not something we initiate, but we have significant education programs—a doctor or a group of doctors, working with their ethics committee for their institution, or one that can apply in a community situation—

Senator DI NATALE: Yes—understood.

Dr Skerritt: applies to be able to prescribe to a group of patients without having to come back anywhere near us for patient-by-patient access.

Senator DI NATALE: You're saying there's over 100 doctors, roughly?

Dr Skerritt: As I've said, we've had 217 SAS B approvals. It's not one doctor who has done 90 of them. There is a spread of doctors. Again, I would have to take on notice the precise number of individual doctors.

Senator DI NATALE: How many doctors are there across the country, do you know?

Dr Skerritt: I'll check with the CMO. I think the figure is about 10,000.

Senator DI NATALE: Do you think it's strange that we've got, say, 10,000 doctors and they can all prescribe codeine, opiates—drugs that people can overdose on and where people

are occasionally diverted to the illicit market and they are fatal in overdose—and yet we only have 100 or so doctors that can prescribe medicinal cannabis?

Dr Skerritt: No—

CHAIR: I'm not sure you need to comment on whether something is strange.

Dr Skerritt: I'm not going to comment on whether something is strange, but I want to correct an error of statement. Any doctor, especially working under a specialist, or any specialist—

Senator DI NATALE: No, a GP can't. If we're going to talk about—

Dr Skerritt: Sorry—can I—

Senator DI NATALE: If I'm a GP in a general practice, I can write a script for codeine—

CHAIR: Can the witness please finish his answer?

Senator DI NATALE: but I can't write one for medicinal cannabis.

CHAIR: That's enough, Senator.

Dr Skerritt: Senator, I just wanted to correct the statement. The way it's framed the assertion is that there's only 100 doctors who have some form of permission ever to be able to prescribe that.

Senator DI NATALE: In the same way as they can write a script for opiates.

CHAIR: Can we let the witness finish his answer?

Senator DI NATALE: Sorry.

Dr Skerritt: The decision of whether a GP or a specialist wants to prescribe medicinal cannabis for a particular patient is one for the prescribing physician. And, essentially, what we are told—because, as I have said, we have had literally probably dozens of meetings with GPs about medicinal cannabis and with specialist organisations this year. There are many of them, the overwhelming majority, are hesitant to prescribe because they have some degree of view that the evidence is not substantial enough.

Senator DI NATALE: And there are many who do want to prescribe and can't.

Dr Skerritt: Well, we would welcome their applications.

Senator DASTYARI: I have one follow-up from that. I'm fascinated by this. Again, I defer to Senator Di Natale, who knows far more about this issue than I do. Does that mean that, if I walk into my local GP in inner-west Sydney, where I live, and I want to be prescribed medical marijuana—now the Senate has already gone through this entire process led by Senator Di Natale about medical marijuana all things that have happened—parking all that for a moment. This GP is in a position now to prescribe me a whole bunch of drugs, some of which, evidence would clearly show, have far more significant medical impacts than medical marijuana. If they also wanted to prescribe to me medical marijuana—and this shows how little I understand this—I was under the impression they would be able to do that, that they could write me a script for that. Are you saying that's not the case?

Dr Skerritt: It depends on the medicinal marijuana product and the condition. Medical marijuana products—with one exception, which isn't widely marketed in Australia—are unapproved drugs. That's why they go through this patient access pathway.

Senator DASTYARI: So the answer is no. They can't just write me a script and I can go down and buy it.

Dr Skerritt: It will depend on the product and it will depend on the condition. For many of those, they will have to seek authority first from the state department of health.

Senator DASTYARI: And how long does that take?

Dr Skerritt: I can't answer on behalf of the New South Wales Department of Health. We are told that, if it's a fairly standard condition—like a child with certain serious epilepsies under the care of a specialist physician for epilepsy—it's very fast. If it's an unusual condition, it will generally go to an advisory committee, which meets fairly regularly, but of course it's really in the hands of the New South Wales health department.

Senator DASTYARI: At the end of this process—and everything the Senate has been through and the disallowance and this and that—we're still not in a position where I can walk into the GP surgery and get prescribed medical marijuana. I can get a whole bunch of other drugs, and some are quite serious drugs obviously.

Dr Skerritt: There's a fundamental difference here. I will repeat myself: these are unapproved drugs. Similarly, with other unapproved drugs, you could not walk in—

Senator DASTYARI: Sure. You have answered it.

Dr Skerritt: You could not walk into your GP and request any of the thousands of other unapproved drugs just off the bat like that.

Senator DASTYARI: How well do you know my GPs?

Dr Skerritt: There is a process for that.

CHAIR: Just one follow-up question from me.

Senator SINGH: You certainly could not in Tasmania; there's still no access—

CHAIR: Is the current scheme in line with advice from the TGA and medical professionals?

Dr Skerritt: Well, even though my spouse says I sometimes do, I don't tend to give myself advice, so let's talk about medical professionals instead. Quite interestingly, all the medical associations are on the record saying that, because this is an unapproved drug, they support the current access pathways. It was interesting that the palliative care physicians actually supported a continued involvement of TGA and state departments in the prescription and approval of medicinal cannabis. These are palliative care physicians and palliative care patient organisations. They actually did not support the changes—and this is on the public record—that the disallowance brought in. So the patient and doctor groups actually do support the additional oversight, recognising that this is a group of unapproved drugs.

CHAIR: Yes. So my understanding is that, apart from one specific drug, none of the products we are talking about here have been through testing, evaluation, double-blind trials et cetera.

Dr Skerritt: There are some double-blind trials underway but they have not been approved either by TGA or by similar bodies in the US or Canada or the UK. That puts them in an almost unique situation, because almost all the other unapproved drugs have at least been approved say in Germany, and they're just unapproved in Australia because the market is

too small here. But a doctor says, 'Well, I know that it works for this particular rare condition' or whatever. Medicinal cannabis is unusual in that, at least as of today, the products have not been through the approvals process—

CHAIR: Anywhere.

Dr Skerritt: from FDA, or the British or Europeans and so on.

CHAIR: Okay. Very interesting. All right, corporate. Have we got anything else there?

Senator DASTYARI: Yes, we have a bit. I know we kind of got cut across to a different issue. I note the chair was doing that to allow for senators' busy schedules. We have just covered off the general discussion review regarding MRI licences. We have talked about the transparency model and IVF success rates, we have discussed the full medical review of Lyme disease, and we are kind of going down the process of talking about the vaccine for the A, C and W strands of meningococcal. I just want to take you to something else very quickly: meningococcal B vaccine on the NIP. Where's the process of that up to?

Prof. Murphy: Meningococcal B vaccine, as you're aware, was rejected by PBAC on the grounds of cost effectiveness in the past on a number of occasions.

Senator DASTYARI: Yes.

Prof. Murphy: And there has not been another resubmission from the sponsor of the currently registered drug in Australia yet.

Senator DASTYARI: Okay. Mr Murphy, I have this thing here. I have a media article here, saying that Mr Hunt has asked you to 'fast-track consideration of listing'.

Prof. Murphy: Of the meningococcal B vaccine?

Senator DASTYARI: Yes. It's Annika Smethurst, *Sunday Telegraph*, 12 March:

A FREE vaccine for a deadly strain of meningococcal could soon be available in Australia following a decision by the federal government to fast-track its consideration.

Prof. Murphy: Are you sure that's in relation to meningococcal B?

Senator DASTYARI: I'm happy to table it but I'll read this paragraph first:

Health Minister Greg Hunt has ordered the nation's chief medical officer consider whether vaccinations for meningococcal B strains should be placed on the taxpayer-funded schedule after it was added to Britain's immunisation program.

Are we talking about the same thing?

Prof. Murphy: Yes, that is meningococcal B.

Senator DASTYARI: I'm happy to table it. It's a simple two-page—

Prof. Murphy: As you're aware, under the legislation, PBAC has to have another application from the sponsor to consider it for the NIP and we haven't received another application from that sponsor.

Senator DASTYARI: Okay. Let's be clear. I understand these things are done at an independent level. Is there currently an application before PBAC for meningococcal B?

Prof. Murphy: Do you want to answer that, Ms Appleyard?

Ms Appleyard: Senator, I actually can't comment on what is before PBAC at the moment, but my understanding is there were two previously failed applications and that what the

company is doing is going away and doing some further research, a carriage study in South Australia, in relation to getting some further evidence to support an application for meningococcal B. That's the best I can tell you in relation to that.

Senator DASTYARI: How does that work? Again, this is my first time doing health estimates, so my apologies if this is a very simple question. But, when something fails, there is a time limit between when it fails and when they're allowed to resubmit, correct?

Ms Shakespeare: There is no time limit.

Senator DASTYARI: So I apply for drug X. It goes through the process, and it fails. I can reapply the next week, the next day?

Ms Shakespeare: There are three PBAC meetings generally each year to consider these things. There are cut-off submission points. So, if there was a rejection from the PBAC at a particular meeting, then the sponsor could resubmit at the next available point.

Senator DASTYARI: When did the carriage study begin? When was the last time this thing failed? You said it failed on two previous occasions, and I've got media reports saying it failed. Was that last year or was that this year?

Ms Appleyard: No, it wasn't this year. It was prior to that.

Senator DASTYARI: So prior to this year it has failed on two occasions.

Ms Appleyard: Prior to this year. That's right, yes.

Senator DASTYARI: So the company has gone away and—again, they can speak for themselves—a layman's interpretation would be that they've failed twice so they've gone away to work out how not to fail. They can speak for themselves. I won't ask you to speak for them, but that would be a reasonable assumption, I think, to make. In that time, if you have been requested to fast track consideration, what does that mean?

Prof. Murphy: We thought that reference was to the fast tracking of the ACWY vaccine, but we'll take that on notice and look at that article. I think, certainly, the minister is interested in getting another application from the sponsor, but the challenge that the sponsor had was the lack of evidence of impact of that vaccine on carriage. That's why the company is doing a carriage study, which is under way in South Australia, and is fairly close to completion.

Senator DASTYARI: But the carriage study started last year. It was last year, wasn't it?

Prof. Murphy: No, the carriage study was announced last year. It has only really been going this year.

CHAIR: Senator Dastyari, I have given extraordinary latitude. We really are getting stuck. I think we should move onto outcome 4, as per the program. I said Senator Siewert could have one question in corporate.

Senator SIEWERT: I did come in just as Senator Singh was asking one. I wasn't expecting this to be on until the relevant portfolio area. Did Senator Singh ask—and, if she did, tell me to go look at the *Hansard* or just say yes or no—about the government's response and when we can expect that? That question is probably more to the minister.

Prof. Murphy: I can answer that. The government response is approved for tabling. It is fully approved, and it will be tabled in the next available sitting of the Senate when it can be tabled.

Senator SIEWERT: Fantastic. It can, of course, be tabled out of session.

Prof. Murphy: We weren't advised that was possible.

Ms Appleyard: We'll definitely be tabling it at the first available opportunity. I can give you that undertaking.

Senator SIEWERT: Thank you.

[09:50]

CHAIR: I thank all the officials for their extreme latitude in that cross-portfolio. I think maybe we don't need cross portfolio next time, given the content. Let's move to outcome 4: individual health benefits. Senator Siewert, do you want to take the call?

Senator SIEWERT: Yes. It's some years since I have asked about midwife services. Is this the right place to ask about midwife services and collaborative partnerships et cetera? If it's not, tell me where I should ask.

Ms Shakespeare: Yes, this is the right place.

Senator SIEWERT: I remember a couple of years ago we spent quite a lot of time on this issue. I'm following it up, given I think it sounds like there have been some changes. Am I correct in my understanding that there has been a change in the requirement for evidence on collaborative arrangements for the provision of midwives who are seeking a Medicare provider number?

Ms Street: Medicare provider numbers are actually a matter for DHS. There's been no change in the policy in relation to the midwives.

Senator SIEWERT: There's been no change to the policy.

Ms Street: Yes.

Senator SIEWERT: Of course, we had DHS last night.

Ms Street: Yes.

Senator SIEWERT: We do usually ask: where do you ask a particular question? I will double-check then that you have had no change in policy.

Ms Street: To the policy that we're responsible for.

Senator SIEWERT: So are you aware that there may be a change in approach, that DHS is taking, to the requirement of the demonstration of a collaborative arrangement?

Ms Street: We understand there are concerns that there may be, but we haven't got into the detail of what that is.

Senator SIEWERT: Okay. If there's been no change in actual policy—well, I'm getting feedback that there is a change. So my question then is: when is it signalled to you that DHS has made a change? It sounds to me like this is affecting the way midwives can deliver their services, yet there hasn't been a change of policy.

Ms Shakespeare: I think the way that the policy and legislation are implemented at DHS is something we would have to ask them to comment on if they've had a change to their systems or other arrangements for monitoring compliance. So I'm not sure that we can comment on that today. As the witness has said, we haven't had a change in policy, but we're happy to follow up with them.

Senator SIEWERT: Okay. So could you take that on notice. I will obviously now put some more questions to add to the list to DHS.

Ms Street: Yes.

Senator SIEWERT: If you could look at that for me as well from your perspective, and at whether you think this does actually affect the way that your policy operates, that would be very much appreciated.

Ms Shakespeare: We'll certainly do that.

Senator SIEWERT: I will just check my other questions to see if I think they should be DHS or here.

CHAIR: We may have to jump around a little bit, because I know there are some senators who aren't currently here who do have some questions potentially in this area.

Senator SIEWERT: Okay. My next question is about the process of how you provide evidence et cetera. Can I just clarify so I'm not wasting the time of both of us: for anything to do with what certification is required and how you demonstrate collaborative arrangements or partnerships, is that up to DHS?

Ms Street: The application is the responsibility of the Department of Human Services, yes.

Senator SIEWERT: Okay. I go back to this issue: where it affects policy, do you then become involved?

Ms Shakespeare: Yes.

Senator SIEWERT: This sounds like it is affecting the policy, so can you expand as much as possible on the question you've taken on notice as to whether this is affecting the policy intent and the way it's actually being applied.

Ms Shakespeare: Yes.

Senator SIEWERT: Okay, thank you. Are you satisfied with the policy for the arrangements right now, or have you been in the process of undertaking a review?

Ms Shakespeare: I don't think that there's been any review undertaken. These collaborative arrangements were negotiated with multiple health providers.

Senator SIEWERT: I remember at the time, yes.

Ms Shakespeare: And, as far as we're concerned, they have been operating effectively since. If there have been any issues in the way that the policy is actually being implemented through application forms and information provided to DHS, we've undertaken that we'll follow up on that and ensure that there aren't any impacts on the policy.

Senator SIEWERT: Thank you. I just wanted to be clear that there has been no policy renegotiation or consideration.

Ms Shakespeare: No.

Senator SIEWERT: Thank you.

Senator GRIFF: Good morning. I'd like to briefly discuss MBS item 55850, which we covered off during the last estimates. As you're aware, this is for the musculoskeletal ultrasound, which has experienced a compound annual growth in use of 30 per cent. In

answer to a question I put on notice at the last estimates, the department said that it undertakes regular compliance to ensure health professionals are claiming Medicare benefits appropriately. Has the department identified inappropriate use of this item?

Ms Shakespeare: We will just get the officers who are involved with our compliance. The answer for this particular item is: no, not at this time. However, this item is something that is being considered by the MBS Review Taskforce.

Senator GRIFF: So you haven't required that they repay any amounts back for inappropriate use?

Ms Shakespeare: No, Senator.

Senator GRIFF: You're not conducting any sort of compliance on this particular issue yourself?

Ms Shakespeare: I'm sorry, Senator. Could you, please, repeat that question?

Senator GRIFF: You're not undertaking any other compliance issues in relation to this item or any other related item?

Ms Shakespeare: There are always a range of compliance activities underway. We may need to take on notice whether there are any investigations, any referrals that have taken place to the Professional Services Review.

Senator GRIFF: So that will be on notice. Thank you. This item was, in fact, pretty much the replacement for 50124 in 2009, and that's where the spike in claims occurred. Are there any clinical benefits that you could state that have come as a result of that item being replaced?

Ms Shakespeare: I'm not a clinician, so I'm not sure that I'm in a position to comment on the clinical benefits of this item compared to the previous item. As I said, this has been referred to the MBS Review Taskforce for consideration, which includes medical experts who will provide advice to the government.

Senator GRIFF: Okay. I look forward to receiving the answers to that previous question on notice on that. Thank you. I would like to now go back to the last estimates where I asked about telehealth rebates for GPs. As you're aware, in the budget psychologists were granted telehealth access for clients from rural and remote areas. When I asked why this wasn't extended to GPs, I was informed that it's a work in progress with targeted consultation with key stakeholders and technical experts. Can you clarify the state of this?

Ms Shakespeare: There would be, potentially, a couple of pathways for the government to consider telehealth items being extended from specialist to general practitioners. One of those would be an application to the Medical Services Advisory Committee or discussions towards change of policy within government. So we're always engaging in discussions with medical colleges—the AMA, as well. But around this we would need to consult with the RACGP. We had discussions with medical groups when the telehealth items were first introduced to the MBS. The clear view from the medical profession at that time was that telehealth was not an appropriate modality for the delivery of initial diagnosis for undifferentiated patients, which is how most people present to general practitioners. If the views of the medical profession have changed, that's certainly something that the government can consider. But we would need to make sure that it was clinically appropriate for GP

services to be provided through telehealth. Perhaps, it may be that there are some services that would be more appropriate for video conferencing than others.

Senator GRIFF: Just on that, are you giving any consideration to extending telehealth access to GPs who have training in Focussed Psychological Strategies?

Ms Shakespeare: The Focussed Psychological Strategies measure allows for services to be provided to patients through video conferencing by allied health practitioners, such as psychologists.

Senator GRIFF: Are you considering extending telehealth access to GPs who have actually had training in that? You're saying that that's not the case?

Ms Shakespeare: It's something that we would have ongoing discussions with the medical profession about.

Senator GRIFF: So you're in discussion with them at the moment—or you've considered that?

Ms Shakespeare: I've had discussions with medical professionals, medical colleges about this—yes.

Senator GRIFF: So where do you go to from there?

Ms Shakespeare: It's not currently government policy.

Senator GRIFF: I'd like to now refer back to the MBS Review Taskforce on after-hours services. Now the minister indicated he'll accept all of the task force recommendations, including that the highest rebates be for GPs who normally work during the day and are called out at night to see a patient. It also recommended that deputising services only be able to claim the non-urgent rebate. Has the department modelled the expected savings from the changes in billing eligibility?

Mr Weiss: The task force report was provided to the minister approximately two weeks ago. We're working through that. We're working on a range of different options for a possible government response to the task force and, as part of that, we are working through various modelling, but that's as far as it's gone at this stage.

Senator GRIFF: In another answer to a question on notice, the department stated that, during 2016-17, a total of 16 practitioners were referred to Professional Services Review over after-hours billing and one was disqualified, I believe, for three months. Was that the case?

Mr Cotterell: Just give me a second; I can give you an update on that. In relation to the 16 practitioners referred to the Professional Services Review in 2016-17 for investigation of potential inappropriate practice for after-hour services, five of the 16 practitioners have been found to have practiced inappropriately. One of those was disqualified from Medicare for a period of six months, including a disqualification from use of one of the after-hours items. Of the five cases in which the practitioner acknowledged inappropriate practice, a combined total of \$890,000 in repayment of Medicare benefits was ordered by PSR. A further two cases were closed without a finding of inappropriate practice, and for eight cases a decision is pending. One practitioner for whom the outcome is pending was fully disqualified from Medicare for failure to respond to a PSR notice to produce documents.

Senator GRIFF: That must concern you.

Mr Cotterell: A number of practitioners have been referred to PSR. We continue to do compliance activity on the urgent after-hours practices.

Senator GRIFF: How many practitioners have voluntarily acknowledged incorrect after-hours claiming in 2016-17?

Mr Cotterell: I might need to take that on notice.

Senator GRIFF: So the \$109,000 you mentioned—

Mr Cotterell: Do you mean the \$890,000?

Senator GRIFF: Are you expecting that to be repaid?

Mr Cotterell: We have debt repayment arrangements that we negotiate with the practitioners.

Senator GRIFF: So you would be expecting that practitioners to actually make that repayment?

Mr Cotterell: That's right.

Senator GRIFF: Looking at repayments generally or outstanding debts, if you like, how many repayments are you requiring back from practitioners at this point?

Mr Cotterell: In relation to urgent after-hours items or generally across the MBS and Medicare?

Senator GRIFF: Yes.

Mr Cotterell: I can tell you that, in 2016-17, we raised debts of \$30 million.

Senator GRIFF: How much, sorry?

Mr Cotterell: It was \$30 million. And we received repayments of \$13 million.

Senator GRIFF: So, with the repayment schedule that you have put in place, is there a standard set of terms or is it just that you negotiate it?

Mr Cotterell: Our starting position is that we ask the practitioner to repay within 30 days. If they tell us they have circumstances in which they can't repay that, we negotiate a repayment schedule.

Senator GRIFF: Out of the \$30 million, are there any particular specialty areas where the bulk of the debt applies?

Mr Cotterell: It's a broad range right across the MBS. From time to time, we conduct campaigns on particular issues. A portion of the debt repaid was from the eHealth practice incentive payments, on which we ran a particular campaign.

Senator GRIFF: Could you provide us on notice with a breakdown?

Mr Cotterell: Yes.

Senator GRIFF: Thank you.

CHAIR: We're still in 4.1. I've got a few questions, and these are going to be very basic questions—I'm fairly new to this space! In terms of bulk-billing rates, where are we at currently?

Mr Weiss: There are a variety of measures of bulk-billing rates. We published in August of this year the bulk-billing rates for the 2016-17 financial year. The bulk-billing rate for GP non-referred attendances for that financial year was 85.7 per cent. The bulk-billing rate for—

CHAIR: So, when people talk about bulk-billing rates in the media, that's generally the figure they'd be using?

Mr Weiss: Generally, yes. The bulk-billing rate for all Medicare services was 78.3 per cent.

CHAIR: I understand where the numerator comes from. What's your denominator in calculating that figure?

Mr Weiss: All Medicare services.

CHAIR: Do we break down bulk-billing rates via regional areas? How granular can we get with bulk-billing rates?

Mr Weiss: We do. We have data that is published according to an ABS classification of remoteness. It's called the Australian Statistical Geography Standard. It breaks it up between major cities, inner regional, outer regional, remote and very remote.

CHAIR: Bulk-billing rates have been trending up recently. That's my understanding.

Mr Weiss: Yes.

CHAIR: How about in the regions?

Mr Weiss: I can give you figures for the last two years here. This isn't just GPs; this is all Medicare services. The bulk-billing rate in inner regional in 2015-16 was 77.8 per cent. It fell very slightly to 77.7 per cent in 2016-17. In outer regional, it was 80.3 per cent in both of those years.

CHAIR: So basically stable in the bush. What is the expected funding growth over the budget cycle in terms of Medicare?

Mr Weiss: Do you mean in dollar terms?

CHAIR: Yes.

Mr Weiss: For total Medicare benefits schedules—this includes the Department of Veterans' Affairs' share of Medicare—the forecast for 2017-18 is around \$23.7 billion.

CHAIR: Sorry, that's the funding growth?

Mr Weiss: That's the funding. It was \$22.9 billion in 2016-17.

CHAIR: And going forward? Have you got those numbers there?

Mr Weiss: In 2018-19, \$24.8 billion; in 2019-20, \$26.5 billion; and, in 2020-21, \$27.9 billion. I don't have growth rates calculated there.

CHAIR: I can work those out myself. Thank you very much.

Senator DI NATALE: I'd like to go to the MBS review as well—firstly, to the trigger for the review. Most of the MBS reviews are looking at specific interventions, whereas this is more urgent after-hours care. Why was it established? Was it just because the costs were spiralling out of control? What was the reason for establishing the review into after-hours care?

Ms Shakespeare: The review into after-hours care was established by the MBS task force. It responded to clinician concerns about the growth in urgent after-hours services and benefits payments.

Senator DI NATALE: But the growth in those services doesn't in and of itself mean that those services are unnecessary, does it?

Ms Shakespeare: That's exactly why there was a review: to examine what was driving the growth and to look into the causes and whether or not there was appropriate practice.

Senator DI NATALE: In terms of what's proposed, can you give me a very brief summary of what the recommendations are?

Ms Shakespeare: This is the task force review and the report of that, which has now been provided to government?

Senator DI NATALE: Yes.

Ms Shakespeare: I'll ask Mr Weiss to read the recommendations from the report.

Mr Weiss: The key thrust of the task force's recommendation is public, so it's on our website. The recommendations are public. Probably the most critical recommendation there is to remove access to the four urgent after-hours items from doctors who work predominantly in the after-hours period.

Senator DI NATALE: Basically, what you're saying is only a person's regular GP could access that claim as that urgent item?

Mr Weiss: A doctor who has worked during the day and is then called out from their home during the evening or during the night to go and see one of their patients—the task force's view was that that doctor did deserve the very high rebate that was associated with the urgent after-hours items.

Senator DI NATALE: What's the rationale for that?

Mr Weiss: Rationale for what, sorry?

Senator DI NATALE: What's the rationale for limiting that item number only to a patient's regular doctor?

Mr Weiss: It's not limited just to a patient's regular doctor. It's a doctor who has worked predominantly in the in-hours time period and has then returned to work to visit a patient in the after-hours period.

Senator DI NATALE: So what's the rationale for that?

Ms Shakespeare: I can read the MBS task force's rationale from their report, which says: The rebates for urgent after-hours services should only be payable in circumstances where a GP who normally works during the day is recalled to work for management of a patient who needs, in the opinion of the GP, urgent assessment.

Senator DI NATALE: I've got the recommendations, but I don't understand the rationale. That's the recommendation, but not the rationale.

Ms Shakespeare: The task force's rationale is set out in its findings on what I have got as page 6 of its report.

Senator DI NATALE: Having had a look at it, I understand that that's the recommendation.

Ms Shakespeare: I can read further:

The higher rebate recognises the additional clinical value provided by, and lifestyle and financial imposts on, GPs who deliver these services to their own patients, the practice's patients or patients of other local practices where on-call work is shared.

Senator DI NATALE: So the lifestyle and financial impost on practising doctors?

Ms Shakespeare: That was the rationale for the task force's recommendation.

Senator DI NATALE: Do you think that's a reasonable rationale—to restrict after-hours care because of the impact on the lifestyles of GPs?

Senator Nash: You're asking for an opinion.

Ms Shakespeare: The government will respond to the report—

Senator DI NATALE: Does the government support that rationale?

Ms Shakespeare: The government is currently considering the recommendations from the task force and will respond to those.

Senator DI NATALE: Do you know how many GPs who currently provide those services, or what proportion of GPs who provide those services, are GPs working during regular hours?

Mr Simpson: I think we'd have to take that on notice.

Senator DI NATALE: Perhaps I'll go back to some of the information that you've already provided me. Can I just confirm that 63 per cent of doctors delivering these services are currently non-VR-trained GPs. That's from an answer to a question on notice you provided me. Can you confirm that figure?

Mr Simpson: The question on notice included all services in the after-hours period from memory, not just the urgent after-hours item.

Senator DI NATALE: But 63 per cent of doctors who are delivering all of those services are non-VR, yes?

Mr Simpson: Yes.

Senator DI NATALE: What that says to me is that, if you're taking that call out from the urgent after-hours item numbers, you're going to be left with 27 per cent of doctors who are able to provide those urgent after-hours services; is that correct?

Ms Shakespeare: There are a range of after-hours items.

Senator DI NATALE: I'm talking about the urgent after-hours services.

Ms Shakespeare: The impact of the task force's report is one thing. We can take on notice the number of doctors who would be affected by the restrictions if they were to be taken up for in-hours compared to out-of-hours doctors. But, as I said, the government's response—

Senator DI NATALE: The question on notice is actually about 63 per cent being the number of people who provide those urgent item numbers. That's an answer you've given me. That's 1031. While you're checking that, what that says to me is that only 27 per cent of GPs are going to be able to provide that service. If 63 per cent of doctors who are currently providing the service will no longer be eligible to do it, you'll be left with 27 per cent of those who are currently—

Ms Shakespeare: I would just like to check on the actual answer we provided to the question on notice to make sure we're not confusing doctors who are vocationally qualified and non-vocationally qualified for doctors who are working primarily in the in-hours period.

Senator DI NATALE: I'll let you double-check that.

Mr Simpson: I have confirmed. Sorry, I had another response to you in mind. My apologies.

Senator DI NATALE: So it is 63 per cent who are providing—

Mr Simpson: It is 27 per cent who are vocationally registered and 63 per cent who are non-vocationally registered.

Senator DI NATALE: What you're doing is taking more than two-thirds of the doctors who are currently providing those urgent after-hours services out of the system because they won't be able to provide those urgent after-hour services using the current item numbers. I suppose my concern is that we know that after-hours care has been a problem in general practice. We can look at the quality of the services that are being provided, but we are taking a huge number of doctors out of the after-hours system to provide those services. How are we going to make up the shortfall?

Ms Beauchamp: Can I just clarify your comment about 'we'—

Senator DI NATALE: The task force committee has recommended—

Ms Beauchamp: This has been a task force recommendation to government. There's been an extensive public consultation process, and the government will be considering its response to that. I think you're raising a number of hypotheticals about 'we' to the department when it's currently under consideration.

Senator DI NATALE: Well, let me express my concerns to the MBS task force. I suppose the other thing to say is about the make-up of those services. The other answer you provided me was on who actually accesses those services, and 18 per cent of those after-hour attendances are provided to kids under 10 and 21 per cent are provided to people over the age of 60. So you have 40 per cent of people being very young or elderly. Isn't it a concern that those people might not be able to get access to after-hours services if the MBS Review Taskforce recommendations are adopted?

Ms Shakespeare: Can I just, please, clarify an answer to your earlier question?

Senator DI NATALE: Yes.

Ms Shakespeare: I think what we need to do is take on notice the number of doctors who primarily work in the in-hours period who have been billing the urgent after-hours items and those working primarily in the after-hours period who have been billing urgent after-hours items. The information that was previously provided in response to question 1031 related to percentages of doctors billing urgent after-hours items, who were vocationally registered GPs and non-vocationally registered GPs, which are different figures. I need to take your earlier question on notice about proportions that would be affected by the task force's recommendations.

Senator DI NATALE: Okay. I'll be happy to look at that.

CHAIR: Sorry, Senator, can I just ask a follow-up question?

Senator DI NATALE: Yes.

CHAIR: I do admit I'm new to this space. What were the task force's concerns about after-hour services? What was the problem that was identified?

Ms Shakespeare: I suppose the primary problem that led to the review was a large increase in the billing of urgent after-hours items, which didn't reflect general trends in increases in GP attendances. In some cases—

CHAIR: So you had a spike in after-hours care that wasn't reflected elsewhere?

Ms Shakespeare: And from the task force's findings it appears that this has been localised to areas where particular after-hours services were established and that were marketing their services directly to patients around the convenience of having a doctor come to their home rather than them going to their doctor's surgery during an in-hours period for a normal consultation.

Senator DASTYARI: Can I follow on from that?

CHAIR: Have you finished your answer?

Ms Shakespeare: That, I suppose, was one of the key findings.

Senator DASTYARI: Just one follow-on from that: you're saying that the increase was in areas where the service was available. That's kind of obvious. Of course that's the case. You wouldn't have an increase for a service in an area where a service isn't available.

CHAIR: Senator Dastyari, I think the question really is: what's driving the growth?

Senator DASTYARI: Fair enough.

CHAIR: Do we have any insight—

Senator DI NATALE: Can I perhaps ask a question?

CHAIR: Sorry. Can I have that question and then we'll go back to you.

Ms Shakespeare: We can talk about the findings of the task force in this area. The task force report states:

The Taskforce is satisfied that the current structure of the urgent after-hours items supports the provision of comparatively low-value medical care and does not represent value for money for the taxpayer.

... ..

In the five years between 2010–11 and 2015–16, the number of urgent after-hours MBS services has increased by 150 per cent ... In contrast, growth in standard GP services over the same period was 15 per cent .

Benefits paid have increased by 170 per cent for urgent after-hours services over the same period ... whilst benefits paid for standard GP services increased by 27 per cent.

The growth in use of these urgent after-hours items is concentrated in some areas of urban Australia.

Most urgent after-hours services are being provided by medical deputising services ...

The growth in the provision of urgent after-hours services appears not to be driven by increasing clinical need for these services, but has coincided with the entry of new businesses into the market with models that promote these services to consumers, emphasising convenience and no out-of-pocket costs.

Many urgent after-hours services claimed as urgent are not truly urgent, as intended when the items were created, and the distinction between 'urgent' and 'non-urgent' appears to be not well understood by many medical practitioners.

Those are the key findings.

CHAIR: What does 'medical deputising services' encompass?

Ms Shakespeare: Medical deputising services have traditionally been deputised by GP practices to provide services to their patients where they need them in the after-hours period, because the surgery is closed and they can't see their regular doctor. The medical deputising services program is administered by the department, and providers can apply for approval as approved medical deputising services for the purpose of accessing the MBS. There has been an increased number of services being provided through these medical deputising services in the last five years, as outlined in the task force's report.

CHAIR: So the strong implication of the report is that there has been an increase in services that aren't based on clinical need?

Ms Shakespeare: They're not urgent, as required by the descriptors of these items under the MBS.

Senator DI NATALE: It would be fair to say that a lot of people would be presenting to emergency departments with non-urgent conditions.

Ms Shakespeare: I'm not sure that I have information about non-urgent presentations at emergency departments.

Senator DI NATALE: Let's just take that as self-evident. Anyone who has worked in an emergency department knows that some people come in who don't have urgent conditions but, for whatever reason, consider those conditions urgent. I suppose the distinction between what's urgent and what's non-urgent is partly a decision that sometimes varies from person to person. There is another thing which relates to that. Have you done any work to look at what the impact is on emergency departments in those areas where those deputising services have been set-up?

Ms Shakespeare: Yes. It's hard to make direct correlations, because there are certain areas where these businesses have been operating where there have been really large increases in the number of services provided. Probably the best correlation would be in the ACT. In the ACT, between 2011-12 and—where I got my first statistics—up until 2015-16, there was a 1,090 per cent increase in the number of urgent after-hours services being claimed. For the same period—although I don't have data that goes up to 2015-16; the emergency presentations data hasn't been provided by the ACT government to the Institute of Health and Welfare for that year—

Senator DI NATALE: Sorry. Has not?

Ms Shakespeare: No. I understand that, when the AIHW put out its report about emergency department presentations this year, the ACT hadn't provided that final year of data. Across the period 2011-12 to 2014-15, there was a 3.7 per cent increase in emergency department presentations. So it doesn't seem that there has been any reduction in ED presentations to offset the large increase in services provided.

CHAIR: Senator Di Natale, Senator Dastyari has a question.

Senator DASTYARI: I know we're going to break, so I want to finish on this topic before that. There are a couple of points on that. You talk about the ACT increase. We're all shaped by our personal experiences. For reasons that I don't understand, the ability to get in and see a GP in Canberra—any politician who has spent time in Canberra would know—seems to be an incredibly difficult thing compared to Sydney. I'm sure there are a whole host of reasons behind that. I'm not sure if some of that drives some of this growth.

Just on the issue of the after-hours GP service: let's look at someone like me. I live in Sydney. I have two daughters. They are six and four. I spend 20 weeks a year in Canberra. My wife, who works full-time, has them for those 20 weeks in the evenings. It will be the case that, from time to time, one of our children will get sick in the evening. One is in child care and one is in year 1 at school. They get classic gastro or whatever. They are always kind of sick kids. It is the reality of modern life. If something like that happens in the evening at, say, 10, 11 or 12 pm or 1.00 am, I know what we do, I know what quite a lot of the parents with kids that age do and I know what mothers groups and whatnot do: they call an after-hours GP service to avoid having to put two kids in a car, drive them to Concord hospital or somewhere and wait there for three hours—which is understandable because their condition is not as urgent as others. They want to get their kid to bed, who has probably got gastro, an ear infection or something, and so they don't want to keep them in a hospital for three and a half hours while someone else is dealing with a life-threatening emergency, which I understand has to take priority in a triage system.

What really worries me in all of this—and I can completely understand the objective of trying to drive down some of these costs; that's not an unreasonable thing—is that people like me will look at some of this and get very, very afraid about what it means. I'm using myself as an example here. Young parents in Sydney are probably a classic group. They get very, very afraid that the cutting off of some of these services or heading towards that path will result in them being dragged back into emergency rooms, which I would assume is bad for the system but also bad for trying to get a kid with an ear infection to sleep at 2.00 am.

Ms Beauchamp: Senator, there's no indication that the government is going to be cutting off services at all. We have a task force recommendation in front of us. That scenario you outlined is absolutely a legitimate scenario for the use of after-hour services. What we are looking at is based on the task force recommendation's report: are there areas where there's not the urgent after-hour use that's required—for example, people booking ahead for an urgent assessment.

Senator DASTYARI: Okay.

Ms Beauchamp: So I think we need to be very clear about the government obviously needing to take that into account.

Senator DASTYARI: There was one more follow-on from that. There was a story about all of this in the *Daily Telegraph* about a month ago. Because we use these services, especially when I'm away in Canberra, it kind of sparked my interest. There was a reference in there to there being inexperienced doctors. Either you're a qualified GP or not. There's no third option; you're not half a GP. Either you're a GP who can show up or not. I think that was a media term, and tabloids do use sensational terms from time to time. That doesn't mean anything, does it?

Prof. Murphy: It does. General practice is now recognised as a medical specialty like any other speciality. A lot of the doctors working in these after-hours deputising services have not completed the GP fellowship, and they're considered prevocational. They've finished their internship, but they're not qualified in general practice.

Senator DI NATALE: They're not in any training?

Prof. Murphy: No, many of them are not in proper training programs. Some of them are GP registrars in training. Some of them are junior doctors who might be doing research during the day and earning some money or waiting to get into another specialist training program, but they've been given access to these Medicare items by special dispensation.

Senator DI NATALE: But my understanding was that you have to be registered as part of some ongoing training program to qualify. Is that correct?

Prof. Murphy: Not for access to these Medicare item numbers.

Senator DASTYARI: Some of this would be, I assume, a bit self-evident.

Senator DI NATALE: I think the witness was about to say something. We've been provided a briefing—because I asked the same question—to say that in fact there was some requirement that, to be able to access these item numbers, you had to demonstrate you were on some sort of training pathway.

Ms Shakespeare: It's a condition of participation in the After Hours Other Medical Practitioners Program that you be working towards your fellowship.

Senator DI NATALE: That's right. So you are working towards your fellowship.

Ms Shakespeare: Yes. I think the concerns are more about whether or not these doctors who are working towards fellowships—whether they're registrars or approved under one of the other medical practitioners programs—need to be supervised.

Senator DASTYARI: Would they be different from the doctors you see at 1 am in an emergency department? It strikes me as logical that the younger, more junior kinds of doctors are the ones that tend to do the crazier hours. If I'm in my mid-50s and have been a GP for 30 years, working at 1 am and driving around to people's houses to see my kids with an ear infection is probably less appealing than to someone of 30 scraping together a deposit in Sydney. I assume the nature of these things would be geared towards younger doctors. Is that the same with emergency departments?

Prof. Murphy: In emergency departments, you could have a range of doctors, from interns through to emergency registrars and emergency consultants, and generally they're working in a supervised environment. You might start off seeing a junior doctor and, if a patient were complicated, they would call in a registrar or a consultant.

Senator DI NATALE: With regard to that story, which I think was in *The Daily Telegraph*, I think the implication—what was the headline? 'Ban on dodgy house calls'. Do you have any evidence to suggest that there are higher rates of, firstly, complaints or, secondly, demonstrated evidence of malpractice than we're seeing in other general practice areas?

Ms Shakespeare: My colleague Mr Cotterell earlier went through some of the compliance work that's underway at the moment. There have been some referrals.

Senator DI NATALE: There'll be complaints across general practice. I'm really just trying to work out if there's a higher proportion of complaints. It's not about billing, because I think billing is probably a separate area, but whether we're talking about evidence of malpractice. The implication in the story was that these are dangerous doctors, and I'm just interested to know if that's backed up by any data you've got.

Mr Cotterell: The Provider Benefits Integrity Division does compliance activities in relation to the whole of Medicare, but we have had a number of reviews of practitioners who are high claimers of after-hours items, and a number of them have flowed to the billings.

Senator DI NATALE: I suppose I'm more interested not in the billing area but in the complaints about the level of service that they've provided.

Mr Cotterell: Yes. It's a big thing.

CHAIR: There would be a distinction between malpractice and excess billing—inappropriate billing based on not showing clinical need.

Mr Cotterell: Correct.

Senator DI NATALE: This was a pretty big smear on the people who were providing those services. The implication was that they were dodgy house calls. I can go through it, but ultimately that was the implication. I think '1800 bad call' was in one of the photos. There were stories about people who'd experienced misdiagnosis and so on. I'm interested to know whether you have any evidence, if we're talking about malpractice and misdiagnosis, to back up that there are higher rates within these deputising services than there are within 9-to-5 general practice.

Ms Shakespeare: That's an area that we are currently investigating.

Senator DI NATALE: Okay. But is there nothing at the moment to indicate that that's the case?

Ms Shakespeare: We will take that on notice to see what we can provide. It's difficult to comment while we've got investigations underway. They haven't been completed, so we'd be providing you with an early view.

Senator DI NATALE: Is that the reference to the further departmental investigation that's made in that report?

Ms Shakespeare: Yes.

Senator DI NATALE: That's focusing on clinical practice, not billing, yes?

Ms Shakespeare: It's focusing on billing, whether or not there's been inappropriate practice and whether or not there are any issues that need to be referred to the Medical Board about inappropriate supervision of doctors who are not fully qualified.

Senator DI NATALE: That gets back to the issue that, if you are a GP registrar in training in a general practice, there's an expected level of supervision.

Ms Shakespeare: Or for other medical practitioners or registrars who are not fully qualified.

CHAIR: Senator Dastyari, did you want to ask more questions before the break?

Senator DASTYARI: I have a long series of questions I'd really like to get to. I think if Senator Di Natale is able to take us out to a break—

Senator DI NATALE: Yes, I have a couple more.

Senator DASTYARI: I can start after the break and get through them.

Senator DI NATALE: I just want to understand how the scheme works. Again, I'm interested in this because it obviously provides a service but, as Senator Dastyari says, clearly people are doing the wrong thing if they're billing inappropriately. That needs to be addressed. At the moment you have to demonstrate that you're on a pathway to vocational registration—is that right? Have I summarised that correctly?

Ms Shakespeare: For the other medical practitioners' programs, they need to demonstrate that they are going to complete the fellowship exams within a particular period of time. 'Pathway' tends to refer to registrar training programs that are specifically set out. But, yes, they're all expected to be on a pathway to qualify as a specialist GP.

Senator DI NATALE: So everybody who signs up for this, at least notionally, is going to be a GP. They've committed to undertake the training that's required and to sit the exams to become a GP.

Ms Shakespeare: They may be a specialist in other specialities as well.

Senator DI NATALE: So either a specialist GP or a specialist in something else. One of the concerns that you've just highlighted is that obviously to demonstrate you're doing that you need to have an appropriate level of supervision. One of the things you're looking at is what sort of level of supervision is provided through these services.

Ms Shakespeare: Yes.

Senator DI NATALE: I have a few other things I'll put on notice.

Mr Cotterell: Can I just clarify something?

Senator DI NATALE: Certainly.

Mr Cotterell: Inappropriate practice is not just about volumes of services. It's about conduct in connection with rendering or initiating services that would be unacceptable to the general body of members of the profession or speciality. So it's not just about volumes; it's also sometimes about, 'Has an appropriate clinical judgement been made?' The Professional Services Review is the only body that, in the end, makes those kinds of judgements about these services.

Senator DI NATALE: Could you give a couple of examples of what you mean by that? Are you talking about ordering a test that doesn't need to be ordered?

Mr Cotterell: In this context, the 'urgent' part of urgent after-hours is in question.

Senator DI NATALE: Okay.

CHAIR: We will suspend briefly.

Proceedings suspended from 10:44 to 11:00

CHAIR: We will resume with the program 4.1.

Senator DASTYARI: Following on from that line of questioning from Senator Di Natale, the task force has obviously released its final report on urgent after-hours primary care services. Secretary, is there a sense of when the government might respond? Is that a this year thing or a next year thing? Is it imminent?

Ms Beauchamp: I prefer not to put a time frame on it. It is absolutely under active consideration by the department with the minister.

Senator DASTYARI: I understand nothing has been finalised, but is this something we're expecting this year or next year? Do you have that information?

Senator Nash: I'm not aware of a timeline. Certainly the government is considering it at the moment.

Senator DASTYARI: It could be imminent?

Senator Nash: That would be an assumption. I'm not aware of the timeline.

Senator DASTYARI: Secretary, I think you used the term 'under active consideration'. What does that mean?

Ms Beauchamp: We're working actively in terms of the task force review—

Senator DASTYARI: You can't define it by using the same word again.

Ms Beauchamp: and obviously there's been a fair bit of consultation and analysis happening. I would expect over the next few months the government would—

Senator DASTYARI: When you say consultation, who is the consultation with?

Ms Beauchamp: The consultation has been with a number of stakeholders directly affected, and obviously—

Senator DASTYARI: So who are the stakeholders?

Ms Beauchamp: In terms of the task force, in terms of looking at some of the submissions and responses that were received, for example, there were 4,500 responses to a survey and 30 submissions received through the task force. We're looking at, obviously with key stakeholders, what some of those options might be to put some informed advice to the minister.

Senator DASTYARI: I'm an outsider here. When we talk about stakeholders, who are we talking about? Are we talking about the people providing the service? It would include GPs, I assume.

Ms Beauchamp: Indeed, GPs.

Senator DASTYARI: What about patient groups?

Ms Beauchamp: I'm not sure about patient or consumer groups. I'd have to ask my officers.

Ms Shakespeare: The report was only provided to government, I think, in the last couple of weeks. Consultations are ongoing. The department hasn't currently consulted with consumer groups, but that would be our intention.

Senator DASTYARI: So you haven't spoken to consumer groups yet?

Mr Weiss: Consultation is an integral part of the task force's processes. A standard part of the task force's getting a recommendation to government involves a public consultation process. Public consultation for after hours occurred from early June until 21 July, from memory. Added to that, the task force itself does have a consumer representative on it.

Senator DASTYARI: When we talk about these consultations, who's leading them? Is it the department, or is it being run by the minister's office?

Ms Shakespeare: The department is conducting consultations. The minister is also talking to stakeholders.

Senator DASTYARI: So there are two parallel processes.

Ms Shakespeare: We work in a very coordinated way.

Senator DASTYARI: To give you an example, when the National Association of Medical Deputising Services announced on 29 September that it had 'commenced a dialogue with Minister Hunt', is that with the Minister directly?

Ms Shakespeare: Yes. The department has also spoken to that organisation.

Senator DASTYARI: Separate to the minister speaking to them?

Ms Shakespeare: Yes.

Senator DASTYARI: Chair, for the sake of committee we're going to place a whole bunch of what we would otherwise be asking today on notice. I also note that there's an inquiry next Tuesday into the medical benefits of private health insurance, which allows us to take some of this stuff to next Tuesday that we would otherwise ask today. So I'm going to try to get through this as quickly as possible. On 22 August the chair of the MBS review announce that the government had, 'accepted 45 recommendations in full and adopted others in a modified form.' How many recommendations were adopted with modifications?

Mr Weiss: For the announcements that you're talking about, there were announcements on 45 recommendations from the task force. Forty-one were accepted in full. The other four were accepted with modification.

Senator DASTYARI: I have the statement here, which is an extract of a government document describing an agreement with Medicines Australia. In it the quote is 'accepted 45 recommendations in full'. I can take this and come back to you about that. You're saying that your understanding is that you accepted 41 recommendations in full and adopted four of them in a modified form—is that correct?

Mr Weiss: That's my understanding, yes.

Senator DASTYARI: . For those that were modified, do you have in front of you the ability to run through for us what the difference between what was recommended and what was modified and accepted for those four? Or is that something you need to take on notice? Is that going to be detailed and lengthy?

Mr Simpson: We would take it on notice. Broadly speaking, it has to do with policy and implementation issues, but we could take it on notice for you.

Senator DASTYARI: There are 45. You take 41 in as they're recommended. With four the decision is made to modify. That gets you to the 45, yes? I'm a bit surprised. That seems to be a bit different than what the statement says, but that could be my mistake here. I'd want to check that. With those four, what's the save spend from this group of—what's the save spend across the whole thing?

Ms Beauchamp: Could I take that on notice? You're asking a broad-ranging question about acceptance of the 45 recommendations and the impact financially. I'd prefer to take that on notice, because we probably need to work through that considering over what period of time we're talking about.

Senator DASTYARI: You'd have some calculations, surely.

Ms Beauchamp: We probably have had some calculations, but I'll take that on notice about the total number.

Senator DASTYARI: Of the 45, some will be saves, some will be spends, which are obviously new items. What we're after is the net save/spend, and whether or not the adoption of these 45 recommendations is a net save or spend. Surely you can say whether it's a net save or a spend?

Ms Beauchamp: I guess I'm concerned at the idea that it's about a savings process. This is more about making sure it's a targeted MBS review with a number of clinical experts around whether there's overuse, inappropriate use, unsafe practises and the like in a number of MBS measures. I don't know—

Senator DASTYARI: Sorry, but this is budget estimates, and the very simple question is, when this process is going in what is the budget impact—whether it's a net save or a net spend. If you're telling me you need to take on notice the specifics of a breakdown of whether it's a save or spend, that's fine. That's reasonable. But you can't come to budget estimates and not know what the budget impact is.

Ms Beauchamp: The purpose of the review was not to have a savings target for the review. The government's been in the process of considering the recommendations as they come due, and I'd like to take on notice the financial impact of accepting each of those recommendations.

Senator DASTYARI: Sure, but—

CHAIR: We are talking about the MBS Review Task Force —yes?

Ms Beauchamp: Yes.

CHAIR: My understanding was final recommendations hadn't been made, that they were still out for consultation?

Ms Beauchamp: I think there are some recommendations that have been included in previous budgets, in the previous MYEFO, and I think they're well publicised, but I want to make sure you're asking about the 45 recommendations, what's been included in MYEFO, what's been included in the previous budget, and what's yet to be published.

Senator DASTYARI: In the 2016 budget you published the net impact of previous rounds. That's not a question, that's just a statement of fact. I guess the question that comes from that is, you've published the impacts of previous rounds. I accept the point that you're making that the objective—you're making a statement or answer that the objective wasn't a cost saving measure.

Ms Beauchamp: Yes.

Senator DASTYARI: That's not really the question I'm asking. My question is, is it a cost saving measure? Regardless of what the objective is, considering we're at budget estimates, what's the budget impact?

Ms Beauchamp: The financial impacts of the 45 recommendations, obviously we'll report it in the next budget update, the next MYEFO. We're going through the process there. But there have been some budget implications reported in the 2016-17 MYEFO and the 2017-18 budget. They're all publicly available.

Senator DASTYARI: Yes, but you would know what the budget impact is.

Ms Beauchamp: We're working through that in terms of what updated figures need to be included in the government's MYEFO statement coming out later this year.

Senator DASTYARI: If there is a save here—because in every previous instance where this has happened this has resulted in a save, if you're talking about overall. The overall 45, it's hard to see, going through this, how it doesn't end up resulting in a broader save. You're saying that any save that will be identified, you're of the view that the result of the 45 will be in the next MYEFO, which is normally about 15 December or 10 December, sometime around that, is that correct?

Ms Beauchamp: That's correct.

Senator DASTYARI: And you're currently going through the budget process to do that?

Ms Beauchamp: Yes.

Senator DASTYARI: Then you have the figures?

Ms Beauchamp: Subject to budget in confidence at the moment, which is the normal process. We're working through—

Senator DASTYARI: That's not what you said to me a moment ago. You said to me a moment ago that you're not in a position to be able to give me the figures about whether this is a net save or a net spend?

Ms Beauchamp: Indeed, and they're subject to development for the next budget update in MYEFO.

Senator DASTYARI: So we have the figures?

Ms Beauchamp: We're working through the figures, yes.

Senator DASTYARI: You can't even say whether the adoption of the 45 is a net save or a net spend?

Ms Beauchamp: It would be pre-empting an outcome that's going to be included in the government budget statement later this year.

Senator DASTYARI: Out of the 45 measures, how many of them involve an increase in expenditure and how many involve a decrease in expenditure?

Ms Beauchamp: I think it would be wise for us to take that on notice, as we're working through that in terms of the budget update.

Senator DASTYARI: If there is an ultimate save in the process of this 45, minister, has there been a commitment—again, this may have already happened in the media, so I may have missed this—to reinvest that in Medicare?

Senator Nash: Indeed, I think the minister said that publicly.

Senator DASTYARI: So any save that's identified as part of this 45 would be reinvested back into the Medicare system?

Senator Nash: My understanding is that that's the case, yes.

Senator DASTYARI: If that's the case—sorry, I'm just trying to cut as much as I can to give us the opportunity to get through more.

CHAIR: And the review process has the support of the AMA and the Royal College?

Senator Nash: Indeed, yes.

Senator DASTYARI: I have a series of questions here that I may actually place on notice regarding the review progress. I'll put them on notice, Chair, if that is going to be helpful. Minister, any savings out of the 45, as you understand it, will be reinvested in the Medicare system. Does that commitment also apply to the future recommendations, not the ones that have been saved so far? There's obviously a process going on right now to get to the end of the 45. The secretary has just identified that the anticipation is that that will be as part of end of year MYEFO. When you made that statement before that all of it will be reinvested back into Medicare, that's referring to the entire strengthening of the PBS, agreement with Medicines Australia on behalf of the innovative medicines sector—that entire saving from that process.

Senator Nash: Clearly this government is investing more than ever into health, but in terms of the specifics of those I'll take that on notice and come back to you.

Senator DASTYARI: Chair, I have a bunch of questions that I will place on notice. I do want to get to the issue of private health insurance and the PBS.

Senator SIEWERT: I want to do hearing services.

CHAIR: We'll go to 4.2 with Senator Siewert. Then we'll go to 4.3 with Senator Griff, then come back to you.

Senator SIEWERT: I want to go first to some of the issues that came up in the joint NDIS committee inquiry into the provision of hearing services through the NDIS. I realise the separation, but there are some issues that have come up that I'd like to ask you that I think come within the purview of estimates. There has been an issue, as you know, around people who are deaf or who have a hearing impairment getting access to the NDIS. One of the recommendations was that the NDIA monitor the eligibility rates for adults with hearing impairments so that we can get a clearer picture of who has been found to be ineligible. Have you been doing any work in that area, or are you aware of any work that's being done in that area?

Ms Garrett: Yes, we continue to work with the NDIA to understand how their interface will work. As you're aware, the hearing program will continue once the NDIS is in full rollout. Since the publication of the NDIS access guidance for hearing we have had a better understanding of what will happen to people who are in the hearing program and who will transition into the NDIS. That work continues.

Senator SIEWERT: At this stage, what are you finding in terms of the work that you've done already?

Ms Garrett: Do you mean in terms of numbers?

Senator SIEWERT: Yes.

Ms Garrett: Based on that access guidance that was published, we are estimating that approximately 36,000 hearing program clients will be eligible for the NDIS. Those clients will be mainly from the community services obligation part of the program.

Senator SIEWERT: Thirty-six thousand?

Ms Garrett: Thirty-six thousand.

Senator SIEWERT: How many then won't be eligible?

Ms Garrett: They will remain with the hearing program.

Senator SIEWERT: But how many of those?

Ms Garrett: Almost the entirety of the voucher program and that small proportion from the community services obligation, which will be approximately 15,000 people.

Senator SIEWERT: From the—

Ms Garrett: Community services—

Senator SIEWERT: CSO?

Ms Garrett: Yes. Currently in the CSO we have roughly 50,000 people.

Senator SIEWERT: So around two-thirds are going to be unable to access it?

Ms Garrett: Around two-thirds.

Senator SIEWERT: You may not know the answer—and I may have to go to NDIA for this. Some of the reports that we were getting through the inquiry were that there were some people who had been found ineligible. There's been some inconsistency in terms of eligibility. Are you aware of how many of those 36,000 have already applied and how many have been found ineligible, or are you discovering a problem in the work that you have done to date?

Ms Garrett: There are a couple of elements to that. People who are found eligible for the NDIS are currently receiving services through the hearing program as in kind. We know about those people.

Senator SIEWERT: How many of those are there?

Ms Garrett: Let me just check that number for you. From the top of my head, it's roughly a thousand.

Senator SIEWERT: A thousand of the 36,000?

Ms Garrett: The rollout is being staged differently in each state, and, because the access guidance hadn't been made available, it's been difficult for people to know whether or not they would be eligible. So that continues on.

Senator SIEWERT: I know I may be stretching it here, but are you aware of clients who are currently accessing hearing services, or the expected 36,000, who have applied but been deemed ineligible?

Ms Garrett: No, I'm not aware of those instances.

Senator SIEWERT: I think my next question then doesn't apply, because you don't know if the people who have applied, who you think would have been eligible, have in fact been found to be ineligible. Those who are currently receiving services who are found to be ineligible will still be able to receive services through your program, won't they?

Ms Garrett: That's right, yes.

Senator SIEWERT: I have to follow up the other recommendations elsewhere. I presume you know about the House of Representatives Standing Committee on Health, Aged Care and Sport inquiry into hearing health and wellbeing of Australia. What's the time frame for responding to that?

Ms Garrett: The time frame for response is six months.

Senator SIEWERT: Do you feel you'll be able to meet that timeline?

Ms Garrett: The role of the department is to coordinate the response, which will come from many different parts of government. We are working towards meeting that time frame.

Senator SIEWERT: Are there any recommendations that jump out at you that you feel are ones that are obviously supportable, or haven't you even got to that point yet?

Ms Garrett: That will be a matter for government.

Senator SIEWERT: Minister? Have you had a chance to have a look at the House of Representatives committee report on the hearing health and wellbeing of Australia?

Senator Nash: I would have to take that on notice. I'm not sure—

Senator SIEWERT: If you could.

Senator Nash: Certainly.

Senator SIEWERT: I understand where Ms Garrett's coming from. It's a matter for government. I'm interested to know your initial response.

Senator Nash: I'm happy to take it on notice for you.

Senator GRIFF: On 4.3, I'd like to raise the issue of adverse drug reactions within the Aboriginal and Torres Strait Islander people and the lack of drug safety for Australia's Indigenous population. The issue was recently raised with me by Plan International Australia takeover participant Sarah Jenkins. According to an article in the *Medical Journal of Australia* last year:

Drug development programs often do not include Indigenous Australians and few randomised controlled trials have been performed in this population.

Does the TGA itself have any reporting requirements for drug safety that include ethnicity of patients?

Dr Skerritt: Thank you for your question. We try to get as much information as possible from our spontaneous reports. There are two ways we get reports on adverse drug reactions—I should go back and explain that. Firstly, there are individual reports, and any doctor or member of the public can provide a report. They go into a publicly available database with personal information de-identified or redacted. The second approach is a compulsory requirement from companies to report adverse drug reactions. If a company finds from compilation of the data that there is a particular problem with a particular ethnic group, they would be required to report that the same way that that would be a requirement in the submission and registration of a drug. For example, there are certain anti-epileptic drugs that are not appropriate for certain people of Chinese descent because of a particular adverse reaction that Han Chinese tend to have more often. I don't know off the top of my head of particular propensities of people of Aboriginal and Torres Strait Islander origin against certain drug types. Obviously, there are higher morbidities of certain diseases: higher cardiovascular disease, higher diabetes and so forth.

One thing we have started to work through is to make sure that there is more information about the ability to report adverse events, and so we work together with other groups like NPS prescribing making sure individual patients and individual communities are aware they can report adverse events directly to us. If we did see, for example—and I don't believe we have—a significant number of people of Aboriginal and Torres Strait Islander origin reporting adverse events to a particular drug, that would initiate a safety review of that product.

Senator GRIFF: So there aren't, as such, randomised control trials, but you're relying on the drug companies to report information back to you if there has been an issue?

Dr Skerritt: So randomised control trials that are carried out for drugs worldwide tend increasingly to incorporate a wide range of populations in them. There's not a requirement in Australia for there to be randomised control trials conducted within Australian Aboriginal communities.

Senator GRIFF: Do you think—I'm asking you for a point of view—

Dr Skerritt: You're asking me for an opinion. I can say that it would be rather difficult and unusual for a country to require a drug trial carried out with respect to a few per cent of a population. What I think is going to be more efficient in terms of cost to the economy and getting drugs to the market for patients such as cancer patients, who really need them, is to have a heightened awareness in different communities. The same would apply if it was a drug that, again, adversely affected people of Middle Eastern or African origin. It is to make sure that there's awareness among people in those communities of the ability both to report any adverse events to us and to discuss them with their doctors. Then, if we can see what is called a signal emerging, we can act on it. I mentioned the case of the signal emerged in Chinese populations with certain anti-epileptic drugs.

Senator GRIFF: Thank you.

CHAIR: Can we move back to outcome 4, if possible, Senator Griff? Have you got more—

Senator GRIFF: Not for four, but I'd like to follow on briefly on one I had earlier for four. I'd like to go back to the statement that there is currently \$30 million worth of inappropriate payments that were made by doctors and requiring repayment. When you have a look at other countries around the world, you see that that's just a fraction of what is being reported elsewhere. In fact, in the US, with \$600 billion of Medicare billings, the justice department has actually charged hundreds of doctors with fraud involving over \$1.3 billion recently. That is obviously a massive amount. Are Australian doctors less likely to commit fraud than their US counterparts? \$30 million is effectively under half of what one would expect when you look at other equivalent countries.

Mr Cotterell: So the \$30 million as a proportion of the relevant expenditure that we look at is something like 0.03 or 0.06 per cent in terms of debts raised. It's a very low percentage. The international benchmark and the benchmark in the private health insurance industry is one per cent of debts raised and recovered. The government invested in this function in the 2016 budget to try to improve our targeting to see what more could come from compliance. The \$30 million in 2016-17 is an increase from 18.8 in 2015-16, so we're already making an improvement there. So I think the answer to your question yes. There's a one per cent benchmark, and we are raising debts that are much lower than that.

Senator GRIFF: Thank you.

CHAIR: Can we just confirm that there are any more in 4.3?

Senator DASTYARI: Yes, I have more.

CHAIR: Okay.

Senator DASTYARI: I want to be clear. I think it was my fault, Minister, and I was unclear to you in the question that I was asking. You answered the question about the outcome of how much money would be saved from the review that we cited earlier. You said that your understanding was that all the savings from that would be reinvested into Medicare. I then asked you unclearly whether that would extend to all future MBS review savings. That's the question I meant to ask. I asked about the 45 and was asking more broadly about future MBS savings and whether there had been any kind of statement or commitment from the government that future savings would also be reinvested.

Senator Nash: Thank you. Again, I would actually need to take that on notice.

Senator DASTYARI: That's fine. I just wanted to make it clear.

I go to 4.3m budget savings. The 2017 budget agreements with Medicines Australia and the Generic and Biosimilar Medicines Association will generate \$1.8 billion in savings. That's straight from the papers. That's my understanding, Secretary. Is that correct?

Ms Shakespeare: That's a five-year figure over the term of the Medicines Australia strategic agreement, yes.

Senator DASTYARI: How much of the funding has been announced for new PBS listings from the budget onwards?

Ms Shakespeare: Between 1 May and 1 November there were \$2.4 billion in listings announced. That's at public list prices. There's also been a further announcement relating to a drug that will be listing on 1 December: ibrutinib. I can get you the figure for that.

Senator DASTYARI: Okay. That \$2.4 billion, was between, what, 1 May and 1 November?

Ms Shakespeare: It was \$2.4 billion and then an additional \$466 million listing for ibrutinib.

Senator DASTYARI: Which listing was that for?

Ms Shakespeare: It's a medicine called ibrutinib, which will be available from 1 December 2017.

Senator DASTYARI: Okay. What I'm trying to get a sense of is, out of that \$1.8 billion in savings, how much of that has already been spent and how much of that is still to be spent.

Ms Shakespeare: It's difficult for us to give you those figures, because the listing figures that we are able to talk about are public prices that are included on the Pharmaceutical Benefits Scheme legislation. Many of these medicines have effective prices where there are rebates paid to the government.

Senator DASTYARI: These figures don't include the rebates.

Ms Shakespeare: That's right.

Senator DASTYARI: Walk me through this. That \$2.4 billion and the \$466 million which you just gave me add up to \$2.86 billion, or \$2.87 billion if you're going to round. That is not including rebate?

Ms Shakespeare: That's correct.

Senator DASTYARI: Okay. Without going to the specifics, even after the rebate, you're saying there's \$2.8 billion in announcements. Some of you take off the \$2.8 billion. That's a

higher figure than it would be because of rebates, and you've raised \$1.8 billion. So a figure under \$2.87 billion is the figure that it would finally be. Is that correct?

Ms Shakespeare: Yes.

Senator DASTYARI: And you saved \$1.8 billion. Generally—without going to the specifics of the exact figures, because I notice you don't list the rebates—are the rebates normally 10, 20, 30, 40, 50 per cent?

Ms Shakespeare: It varies for every medicine.

Senator DASTYARI: Across the PBS, what is it? What's the benchmark? Roughly what do we work towards?

Ms Shakespeare: What we can give you are the last published aggregate rebate numbers, which would be for 2015-16. I don't think we have published for 2016-17 at this point. It's published in the PBS expenditure and prescriptions report. We don't have the data here with us. We'll take that on notice, but it is publicly available.

Senator DASTYARI: I understand it will be and that that's a detailed document that obviously you have spent much time with. Ms La Rance and Ms Smith, are we talking about 20 per cent, 25 per cent, 30 per cent? Without the exact figures, what ballpark are we talking about?

Ms Shakespeare: We'll need to take it on notice.

Senator DASTYARI: You don't know?

Ms Shakespeare: We'll need to take it on notice.

Senator DASTYARI: Sure, but the question wasn't whether or not you know you have to take it on notice.

Ms Shakespeare: The figure changes each year.

CHAIR: The question's been taken on notice. Let's move on.

Senator DASTYARI: This is ridiculous. When can someone get that information to us? There's a department here with, what, 50 people sitting next door and 30 people sitting in here. This is your own report. This is a basic benchmark about a rebate.

CHAIR: Senator Dastyari, the question has been taken on notice. They have a date by which they have return questions on notice. Can we move on?

Senator DASTYARI: I'm sorry, Chair, but this is ridiculous. These are basic, fundamental questions of how the PBS operates, and they're telling me the department can't—their justification is it's all part of a public report. They've got 50 people sitting here; surely someone can get the figure.

Senator SINGH: Isn't it publicly available anyway, so shouldn't they know?

Senator DASTYARI: Shouldn't you know?

CHAIR: Shouldn't you know?

Senator DASTYARI: No! We're here asking them questions. This is Senate estimates. They get paid full time. There's an entire department with 50 people sitting here. This is a basic figure from two years ago as to how they benchmark the PBS. They won't give us a ballpark figure and saying they can't get an answer.

Ms Shakespeare: There are many different medicines listed on the PBS. We probably have better capacity to answer specific questions if you gave us some notice, but we can go and look up that figure and provide it today.

Senator DASTYARI: If you can look that figure up—it is now 11:37—surely that's a figure that you can get to us in the next little while. I'll move on, but I'm sure someone from the department is watching this and can send you, the minister or the secretary an email with a figure. I can't believe you wouldn't bring that information with you.

The government document *Strengthening the PBS: agreement with Medicines Australia on behalf of the innovative medicines sector* says:

Should the cost of new and amended listings recommended by the PBAC exceed the further available savings from the Agreement, then, as with current practice offsetting saves will need to be identified, or additional funding included.

Have new and amended listings exceeded the available savings from the agreement?

Ms Shakespeare: That clause refers to the government's commitment to list all positive recommendations from the Pharmaceutical Benefits Advisory Committee, and the government has continued to meet that commitment. The government has a commitment to list all medicines that receive a positive recommendation from the Pharmaceutical Benefits Advisory Committee on the PBS.

Senator DASTYARI: That wasn't the question. The question was: have new and amended listings exceeded the available savings from the agreement?

Ms Shakespeare: I think that, effectively, what you're asking me is a variation on the question for which we said before that we can give you the publicly available prices for the medicines. We do not provide the effective prices.

Senator DASTYARI: Okay. But, under that basis, it's impossible for us to ever verify if the government is keeping its commitment.

Ms Shakespeare: These are all matters that are considered by the government through budget processes.

Senator DASTYARI: Yes, and we're at budget estimates to investigate those processes.

Ms Shakespeare: We can talk to you about published budget decisions.

Ms Beauchamp: Sorry; just to confirm in terms of the government keeping its commitment: the commitment has been made and Ms Shakespeare confirmed that the government will list medicines recommended by the Pharmaceutical Benefits Advisory Committee and will continue to do so.

Senator DASTYARI: Yes. My question was about the statement that came from the government. Again, I'm quoting the government's own document here:

Should the cost of new and amended listings recommended by the PBAC exceed the further available savings from the Agreement, then, as with current practice offsetting saves will need to be identified, or additional funding included.

This is my understanding of reading that document and, if I'm understanding this incorrectly, please correct me. It sounds like the government said that we have identified \$1.8 billion in savings. That is money that is going to be spent for new listings. If anything above \$1.8 billion is identified, then, following the procedure that already exists, you have to find savings

or offsets to go beyond that. Effectively it's saying that, because of what we've done, there's an extra \$1.8 billion, but, for anything beyond that \$1.8 billion envelope that we've identified, we'll still have to follow the same kind of procedure of finding offsets or savings. Is that—and correct a layman's interpretation of that portion of that agreement—correct?

Ms Beauchamp: To meet the government's commitment, we would have to find money somewhere to keep listing.

CHAIR: But it would be correct to say, wouldn't it, that there's not a single line in the sand you can draw? This is constantly moving. Older drugs will fall off the system—whether that's because they're just no longer being prescribed or because they're no longer considered a worthwhile drug to have in the system—and new drugs come on. The government's got a policy of listing all drugs recommended by the PBAC, which hasn't always been the case. So there's not one line in the sand you can draw—is that correct?

Ms Beauchamp: That's correct. In addition to that, prices change over time as well.

Senator DASTYARI: What your saying is that there's been a figure of less than \$2.866 billion that has already been committed to, and you have an additional revenue component of \$1.8 billion in already identified savings. What you're getting for me is, in the previously published 2015-16 figures, what that gap was, or what the rough proportion—noting that nothing will be exactly the same—was between what was the listing in 2015-16 and the overall rebate component. Is that correct?

Ms Shakespeare: We can get you that information. Whether it relates in terms of a proportion to a different year with different medicines and different listings is another question.

Senator DASTYARI: Sure. Explain to me the decision why the rebates aren't released. Is that a commercial in-confidence agreement between yourself, and is that to protect the supplier in international markets? If the premise should always be that, when it comes to public expenditure, they have a right to know—I'm sure there's a lot of history behind this—why isn't that public?

Ms Shakespeare: Australia is a jurisdiction that applies structured health technology assessment to medicines to ensure that we are deriving value for money in terms of the prices that are paid. For many medicines, the drug companies would be less willing to bring those drugs to Australia if it became internationally known what those effective prices were. So, in order for us to ensure that the Australian community can continue to access new innovative life-saving drugs, we offer the opportunity to sponsors to negotiate confidential, cost-effective prices—

Senator DASTYARI: I can understand that at a drug-by-drug level, and I assume this has been a practice that's been going on for a long period of time across many, many governments. There's no politics here, per se. I don't understand—I guess this is probably a question for the minister, because you'd be following their directive, and maybe you want to take this on notice, Minister—what the rationale is to not release that information at an aggregate level at an earlier period rather than just retrospectively.

Senator Nash: You're right, I would need to take that on notice for you. But I will note that clearly we have a commitment to all of these medicines to list them. Clearly, that's unlike the Labor Party in government who didn't and who did stop listing medicines approved by the

PBAC in an attempt to cut costs. I think there's a very distinct clarity between what the coalition do and what Labor do—

Senator DASTYARI: We were going so well, Minister! We were doing so well!

Senator Nash: You're inferring something—

Senator DASTYARI: No, that's fine. I was being very—

Senator Nash: You're asking a series of questions. I was merely providing you with my view in answering them.

Senator DASTYARI: Let's do this then. The commitment from the government has been to list all of the items. What is the period between the PBAC recommendation and the listing of these? Is there a benchmark period of a date between the PBAC recommendation and the listing?

Senator Nash: I'd need some advice on the process period.

Ms Shakespeare: We work through the post-PBAC processes as quickly as possible. They're of varying complexity for different medicines. One of the things that can affect the amount of time taken is the complexity of the restrictions on the drugs to make sure that it's provided only to the patient population in which the clinical experts, the Pharmaceutical Benefits Advisory Committee, have found that it will be clinically effective and cost effective. There are also quite—

Senator DASTYARI: Explain that again—one of them is what?

Ms Shakespeare: The restrictions are the patient population characteristics that appear in the Pharmaceutical Benefits Scheme so that doctors know which patients are eligible to access medicines under the PBS with PBS funding. Sometimes these can run to dozens of pages long. We have to develop those restrictions and agree them with the PBAC, to make sure that we're accurately reflecting their recommendations, and also with the sponsor, to make sure the sponsor is happy with the recommendations. That process takes some time. We also need to negotiate deals for medicines that are going to have either special pricing arrangements, where there is a public price published, or an effective price. There can also be patient caps that need to be negotiated or expenditure caps, and these take varying periods of time to negotiate with the sponsors.

Senator DASTYARI: I accept that. You get a recommendation from PBAC to list a drug. You're saying there are obviously guidelines and a process that's followed between that and the availability of it for the patient—correct?

Ms Shakespeare: Yes, between that and listing on the PBS.

Senator DASTYARI: Do you measure against a benchmark? You have a 90-day benchmark or 120-day benchmark or per cent of hitting that benchmark.

Ms Shakespeare: We do not currently have a benchmark because it is so variable for different medicines. However, we have agreed as part of the strategic agreement with Medicines Australia to work on reducing the period of time between the PBAC recommendation and listing on average. It has to be work that we do on average because there is so much variation between individual drugs because of the complexity of their patient populations.

Senator DASTYARI: Obviously, as a layman or someone who hasn't been working in the department or the medical sphere for a long period of time, when we talk about this period—and I understand it varies—are we talking about normally a three-month, six-month or nine-month period, accepting there'll be outliers? Are we talking about a several-year process or a half-a-year process? What would be the standard type of period we'd be expecting, noting that not everything will fit into that?

Ms Shakespeare: We generally try and get all of these pieces of work done within a few months.

Ms Beauchamp: If I could add to that, like you, I'm new to the portfolio, but listings in the order of 1,500 new medicines over the last few years are a pretty good record. As Ms Shakespeare said, with the variability in the types of drugs that are coming forward, it's very difficult to give a benchmark. We do it as soon as possible.

Senator DASTYARI: To meet the government's commitment that new cost offsets need to be found for any listings, after the PBAC comes with its recommendation, does the cost offset identification process happen after or before the PBAC recommendation?

Ms Shakespeare: That's a budget process, so it happens after we have a positive recommendation from PBS.

Senator DASTYARI: You'll get a positive recommendation from PBAC. Then, before it's listed, it goes through a separate process, which is the identification of how and where the savings will occur before it's publicly listed to meet the government's commitment of cost neutrality—correct?

Ms Shakespeare: We seek government decisions, which involve financial commitments that go through a budget process.

Senator DASTYARI: The answer is yes, then?

Ms Beauchamp: Along with the consideration of a number of other matters that Ms Shakespeare—

Senator DASTYARI: What other matters are being considered? That seems pretty straightforward. I don't know why you seem so hesitant to say yes to that. I don't quite understand.

Ms Beauchamp: I'm not being hesitant. Of course you have to go through some process after the advice has been given, but I think Ms Shakespeare spoke about the sorts of things that are under consideration.

Senator DASTYARI: You aim to do part of this process in a couple of months. Because of the complexity of some drugs, it takes longer than that. Ideally, if some things are very simple, it might be even a little bit shorter than that. I assume there are a whole bunch of considerations—the availability of the drug, commercial agreements. There are all these things that have to happen before a decision is made and it's available for my doctor to write it on a script for me and hand it over to me. A lot of things happen in between. One of those things is the identification of savings—correct?

Ms Beauchamp: One of the things is a consideration of budget impact and cost, and, yes, we do take that into consideration.

Senator DASTYARI: That's done by you, by the department, and that has to be completed before the minister will sign off—correct?

Ms Beauchamp: That's correct.

Senator DASTYARI: One of the processes that take time is the identification of savings. I assume the internal complication of something like PBAC is that they are making a lot of decisions. It is very complex and has a lot of factors. Cost isn't the matter that they're looking at, per se. Finding offsets isn't what they're looking at. That's done by a government process afterwards. Part of this process that takes several months is the identification of savings.

Ms Shakespeare: The budget and financial commitment work happens in parallel with all of the other work that we need to do after a PBAC recommendation to achieve a listing. The budget process can vary depending on the overall cost of the medicine and the impact on the forward estimates.

CHAIR: Can I ask a follow-up, Senator Dastyari?

Senator DASTYARI: Sure.

CHAIR: What is the flow here? How many drugs are we seeing coming into the system? Do you look at financial years? Is it budgetary processes? What sort of time frames do you use?

Ms Shakespeare: We make the Pharmaceutical Benefits Scheme on the first day of every month, so there's a constant stream of listings.

CHAIR: There's a constant flow on. Is there a constant flow off as well, but I assume much smaller?

Ms Shakespeare: Yes, there are constant updates where we have medicines being delisted by companies that request delisting. We have other processes for price reductions. We negotiate price reduction sometimes where there are market circumstances that would suggest that we are paying too much. We have postmarket reviews that may make recommendations about price reductions to medicines. There are a lot of different processes impacting on the PBS that happen year round.

CHAIR: How many would have been listed since budget? Do you record on that basis, or since the beginning of the financial year or the beginning of the calendar year—however you do it.

Ms A Smith: I've only been in the role for nearly two weeks, so, if I can't answer the full question, I will go to my colleagues. To give an indication, I can give you advice from 1 May 2017 to 1 November 2017. That brief period there would have been following PBAC meetings. There were 156 listings. To give you a longer-term time frame, from 1 October 2013 to 1 November 2017, there were 1,537 listings.

CHAIR: Does the department know how many people would be expected to benefit from those listings at the time of listing?

Ms Shakespeare: It varies for each medicine. We could give you some examples.

CHAIR: Yes, some examples—just one would be fine.

Ms Shakespeare: For the medicine I mentioned earlier that we'll be listing on 1 December—ibrutinib, which is for the treatment of refractory chronic lymphocytic leukaemia

or small lymphocytic lymphoma—the estimated number of patients that will benefit from that is 920.

CHAIR: Does the department track that? Do we have a sense of how accurate we are in those determinations?

Ms Shakespeare: Yes. The Pharmaceutical Benefits Advisory Committee has a subcommittee called the Drug Utilisation Sub Committee, which monitors actual drug utilisation compared to the estimates that were considered at the time of listing to make sure that we don't have medicines being used in much broader patient groups than expected, because that would potentially mean that they're being used in patients for which the medicine has not been demonstrated to be clinically effective or cost effective. We also have a structured program of post-market reviews, where the Pharmaceutical Benefits Advisory Committee can ask the department to look into the way certain medicines are being used, and make recommendations on that. There are several of those reviews under way at the moment.

CHAIR: And what sort of accuracy range is it—was it within 30 per cent, up or down? Does it vary wildly? Do some drugs absolutely take off, and prove to be such a huge benefit that their rates are much more significant than originally expected?

Ms Shakespeare: That can happen for individual drugs. If you wanted an overall average between expected patient usage and actual, we'd have to take that on notice.

CHAIR: No, that's fine. The point I'm getting to is—back to my original point—that this is a moving feast. You've got a lot of variables flowing into the actual cost of the system over time, and so drawing a hard line in the sand at any point, to me, doesn't really make a lot of sense. But that's probably a comment! Back to you, Senator Dastyari.

Senator DASTYARI: Thank you. There's a fair bit here, so let's try and get through this as quickly as we can. Secretary, are you aware of companies being told that the listing of PBAC medicines is delayed because of lack of identification of cost offsets?

Ms Beauchamp: Personally, no. I just wanted to confirm Ms Shakespeare's comments that those budget considerations are done in parallel. I would have to take that on notice or ask Ms Shakespeare to answer that question.

Senator DASTYARI: Ms Shakespeare, are you aware of companies being told that listing of a PBAC recommendation is being delayed because of lack of cost offsets?

Ms Shakespeare: No, I'm not aware of that, Senator.

Senator DASTYARI: I saw this in a statement but I wanted to check if this is your understanding: no new PBS listings are going to be announced outside the budget and MYEFO processes, in that they will only be done at budget and MYEFO, at those two times of year. Is that correct?

Ms Beauchamp: I think there have been listings announced outside of the budget process, and the one that Ms Shakespeare referred to was very recent.

Senator DASTYARI: I think what they mean is that the costings for them will be counted then; I think that's the discrepancy there. With the gap between something being approved by PBAC and it being listed on the PBS: how many drugs are in that period, or going through that process?

Ms Beauchamp: Currently?

Senator DASTYARI: Currently.

Ms Beauchamp: I'm sorry, can you repeat the question please, Senator?

Senator DASTYARI: Between the PBAC listing and then the final outcome being listed on the PBS: how many drugs are in that process at the moment—in that limbo?

Ms Beauchamp: So are you asking for drugs that were recommended at the July meeting of the Pharmaceutical Benefits Advisory Committee?

Senator DASTYARI: Or that have been recommended, full stop. What's the backlog between those that have been recommended and those that have been listed?

Ms Shakespeare: From the July meeting of the Pharmaceutical Benefits Advisory Committee, we had a total of 25 submissions recommended which will be going through the listing process now.

Senator DASTYARI: So that is 25 in July. And how many from those in previous recommendations are yet to be listed?

Ms Shakespeare: Are you talking about previous meetings?

Senator DASTYARI: Yes.

Ms Shakespeare: I'd need to take that on notice.

Senator DASTYARI: Okay. You've partly answered the question. You're saying that at the last meeting there were 25, that was July. You seem to be saying that around a six-month period tends to be standard; so out of those 25, none of those have yet made it onto the PBS. Is that correct?

Ms Shakespeare: I'm not sure, I would have to take that on notice.

Senator DASTYARI: And the question following from that is: what is the backlog from before that? Did you say that PBAC meets three or four times a year?

Ms Shakespeare: Three times a year.

Senator DASTYARI: At previous meetings of PBAC there would have been recommendations. How many of those earlier recommendations have made it onto the PBS and how many are still waiting to make it onto the PBS, as of whatever point in time the information is available? Why don't we make the question more specific and ask: as of today, how many of those from earlier months have made it onto the PBS, and how many have not made it? You're taking that question on notice, is that correct?

Ms Shakespeare: Thanks, Senator.

Senator Nash: Senator, it might assist just to run through the listings since the budget.

Senator DASTYARI: Yes.

Senator Nash: Entresto for chronic heart disease, \$514.6 million; Opdivo, I think it is, for lung and kidney cancer, \$1.1 billion; Stelara for Crohn's disease, \$378.5 million, and ibrutinib for leukaemia and lymphoma, \$466 million.

Senator DASTYARI: And that's what gets us to that \$2.86 billion that we were talking about a moment ago, is that correct?

Ms Shakespeare: Senator, if you'd like that figure broken down I'd need to take it on notice. There are a lot of other listings not included in the ones read out.

Senator DASTYARI: Okay, if you can take that on notice; thank you. It sounds like you wouldn't have this information, but what's the oldest positive recommendation by PBAC which is yet to be listed on the PBS?

Ms Shakespeare: Senator, I think we'd have to take that on notice. There is actually a PBAC time period, and if a positive recommendation hasn't been actioned in that time period then the positive recommendation is rescinded, and occasionally that happens because a medicine's company decides not to list.

Senator DASTYARI: What is that time period?

Ms Shakespeare: I'd need to check that. I'll take it on notice.

Senator DASTYARI: Okay. You're saying—and there are reasons behind this, one of which could be the company—that if something gets a positive recommendation but if the time between that positive recommendation and the listing on the PBS goes beyond a certain period of time, then the recommendation gets extinguished. Is that right?

Ms Shakespeare: That's right, by the PBAC. It is after five years. If it hasn't been listed, then they rescind their recommendation, and if the company wants to list that medicine, it needs to reapply.

Senator DASTYARI: Can I ask a question then, and you can take this on notice. Can you cite the instances in the past five years of drugs being rescinded because they haven't met that period of five years? How many drugs are we talking about? Can that can be broken down to the granularity of what the specific drugs are? I assume this is not the most common thing to have happened.

Ms Shakespeare: No.

Senator DASTYARI: But it appears there are instances of this having happened. Is that a fair statement?

Ms Shakespeare: That's correct, Senator.

Senator DASTYARI: Can you take on notice, more specifically, which PBAC positive recommendations are yet to be listed on the PBS. Can I get, as of now, all of those that were recommended in 2014, 2015, and 2016 but have not made it onto the PBS at this point in time? In July 2016, PBAC recommended the listing of the combined diphtheria-tetanus-acellular pertussis vaccine called Boostrix for immunisation of women in the third trimester of every pregnancy. Is that something you're aware of?

Ms Shakespeare: I'm not aware of that particular recommendation. I would need to go and get you more detailed information.

Senator DASTYARI: I'm pronouncing this terribly wrong, so my apologies to the million people I've probably offended right now; English is my second language—but the recommendation was made in order to reduce pertussis disease in the mother and, particularly, early onset infant disease. Someone contacted me to say that Boostrix is still not available on the National Immunisation Program. The Immunise Australia Program website has confirmed that it's not available. This was 16 months after the recommendation. Why is this not yet listed?

Prof. Murphy: I can answer that question, Senator. I should say at the outset that the vaccine is available across the country for pregnant women, funded by the states at the

moment as an interim measure. So it is available free for all pregnant women. The PBAC made a positive recommendation in July last year, but they've requested ATAGI, our specialist immunisation advice group, to consider before listing the whole pertussis immunisation schedule. There are other pertussis schedules—

Senator DASTYARI: Sorry; this is whooping cough, is that right?

Prof. Murphy: Yes.

Senator DASTYARI: Can I call it whooping cough and not pertussis?

Prof. Murphy: You could, Senator.

Senator DASTYARI: Because after I heard you pronounce it and me pronounce it, I got very embarrassed!

Prof. Murphy: ATAGI did some initial work, and that went back to PBAC in January this year, and they've requested some further analysis, because they were quite keen to see whether we could drop one of the other immunisation time points for pertussis—because the immunisation schedule has a number of drugs on it. That advice from ATAGI has been completed and we'll be going back to PBAC—

Senator DASTYARI: Yes; that advice was completed in March though, wasn't it? I have a copy of their release here.

Prof. Murphy: No, the ATAGI advice wasn't completed in March. ATAGI did two bits of advice. One completed last year, and one that's been completed this year.

Senator DASTYARI: What I have got here is—again, it was on their agenda—ATAGI's program. My understanding is that they gave the information back to you in March. Is that not correct?

Prof. Murphy: No. ATAGI only completed their advice recently, and it's going to be considered at a future PBAC meeting.

Senator DASTYARI: Okay.

Prof. Murphy: We are very confident, Senator, that this listing will take place, but we need to be sure what the place of maternal pertussis is in the whole pertussis regimen.

Senator DASTYARI: I have the extract from the 27 March ATAGI meeting. Under the official name of 'whooping cough' it says: 'The ATAGI review endorses advice to PBAC on the clinical place and effectiveness of vaccines currently listed in the schedule. This advice included determination of the relative contribution of this.' This is all publicly available information. You are say that isn't a complete picture of the advice they gave and, after March, they came back to you with more. I suppose my question is: if they gave you the final piece of advice in March why hasn't anything happened now? You say that that is not the case, you were given the final piece of information after—

Prof. Murphy: I have to take that on notice. My understanding was that that advice has now been completed by ATAGI and it's waiting for a further PBAC consideration to review that because that advice has not yet been back to PBAC.

Senator DASTYARI: Okay.

CHAIR: Senator Dastyari, are you finished with this line of questioning?

Senator DASTYARI: I have only a tiny bit to go, so let me get it done and I'll get out of your hair. In March PBAC made an initial recommendation listing on the NIP of another drug called Adacel. These two recommendations for vaccines were to be listed for NIP for pregnant women to reduce whooping cough. There's been no progress on that either. That hasn't been listed yet either has it, Professor?

Prof. Murphy: Which drug are you talking about, Senator?

Senator DASTYARI: I'm saying there was, for the whooping cough, a vaccine called Adacel.

Prof. Murphy: Is that a brand? There are different brands.

Senator DASTYARI: It is. It's another one as well.

Prof. Murphy: It's the same thing.

Senator DASTYARI: That's tied into the same process?

Prof. Murphy: Yes.

Senator DASTYARI: That was looking at the one that was looking at all the vaccines.

Prof. Murphy: Yes. The recommendations are for those vaccines in general and then, once a decision for listing is made, we go through a procurement process to make sure we get the most cost-effective supplier.

Senator DASTYARI: In July 2016 a vaccine for the prevention of pneumococcal disease, Prevnar, was listed on the NIP. That one hasn't been listed yet either, has it?

Prof. Murphy: No, that's still undergoing a consultation process because, before we finally list it, we have to change the immunisation schedule and do a range of consultations, and then the immunisation schedule is finally approved by the NHMRC. That consultation is under way at the moment.

Senator DASTYARI: When do you anticipate that will be completed?

Prof. Murphy: I'll have to take that on notice, too.

Senator DASTYARI: In November 2016 another drug, Technivie, for chronic hepatitis was also recommended for listing on PBAC. That hasn't been listed either.

Prof. Murphy: I'd have to refer that one to my colleague.

Ms Shakespeare: Senator, our understanding is that that one hasn't been listed because it hasn't secured TGA registration yet.

Senator DASTYARI: Okay. To save us going through all of these, I note you have already taken on notice the gap between those that have been positively identified and those that are outstanding. You have already taken on notice looking at the list of what those drugs are that have and haven't been approved and the time frame. Is it perhaps possible to add, where appropriate to that table,—and it will save us at future estimates having to go through the list—where it is up to in the process? It sounds like different drugs at this point in time are in different parts of the process. We have had different information as to where the drugs related to whooping cough were up to, for instance, as opposed to this other thing. If you can give a brief summary of where in the process you see those drugs are up to insofar as it is possible to be provided. I think you then might be able to take a lot of this on notice and we can then move on. Is that something that you would have available, Ms Shakespeare?

Ms Shakespeare: Yes. I think we will probably have to provide different explanations of processes for the vaccines that go to the National Immunisation Program and the medicines that go to the Pharmaceutical Benefits Scheme.

Senator DASTYARI: Minister,—I don't want to misquote or paraphrase you—at the last estimates you said that a proportion of the \$1.8 billion of savings that had already been identified would go into the contingency reserve for future listings. What is that proportion?

Senator Nash: I'd need to take that on notice for you, Senator.

Senator DASTYARI: If the \$4.18 billion is also listed as a savings measure for the health portfolio—you can take this on notice—that's not going to be double listed, then, is it?

Senator Nash: I'll take on notice for you.

Senator DASTYARI: I asked the question very specifically, for the people taking on notice.

Senator Nash: Absolutely, of course.

Senator DASTYARI: In relation to the savings, Minister, last estimates you told us that a proportion will go into the contingency reserve for future listings. The question is: what is the exact proportion of that that is going to go into the contingency reserve future savings? Also, can we get confirmation that there isn't going to be a double booking—that if the \$1.8 billion is also listed as a savings measure for the health portfolio, it hasn't been recorded twice? I'm sure it hasn't, but can you just have the people who do the paperwork and look at these things confirm that?

Senator Nash: Certainly.

Senator DASTYARI: And also at the last estimates we were told that some of the \$1.8 billion had already been spent on medicine-related costs. Are we able to get a breakdown of what these are, how much has been spent now and how much had been spent at the point of the last budget estimates?

Senator Nash: I will ask if the officials have that.

Ms Shakespeare: We'll need to take on notice the amounts that were included in the budget back in May, but we can certainly provide that information.

Senator DASTYARI: Thank you.

Senator ROBERTS: Thank you for appearing today. I have been informed that doctors preparing the paperwork for an application for medical cannabis under the approved prescriber scheme are required to spend not less than 40 hours for a patient-class approval, and 100 hours for a single patient subscriber application. This information is based on actual times reported by those doctors. What benefits under the Pharmaceutical Benefits Scheme do those doctors receive for spending that amount of time on a single application?

Ms Shakespeare: Certainly the information around the process for that medication—I think Professor Skerritt could answer.

Dr Skerritt: I think that some of the terminology you're using isn't the Commonwealth's. In other words, the reference may be to time spent under various state schemes, and the level of detail required by the states does vary. Under the Commonwealth Authorised Prescriber Scheme, it does require some hours, and the number of hours required depends on, obviously,

the complexity of the patient group, the number of doctors and so forth. I don't believe there's any time requirement, and so in use of the word 'required' I think you mean that they've reported it.

Senator ROBERTS: The doctors are saying this is how long it takes.

Dr Skerritt: Yes, time they're spending. For an authorised prescriber, I wouldn't be surprised that the whole process could take 40 hours, but of course it then enables many dozens or potentially up to several hundreds of patients to be treated, and so that's why it's a good return on investment of time. There are no pharmaceutical benefits payable for these products because they're not registered products by TGA. As you've heard in the previous testimony, a prerequisite for consideration by the Pharmaceutical Benefits Advisory Committee for PBS listing of a medicine is that it must be a medicine approved by TGA. TGA would welcome an application, accompanied by suitable evidence of safety, efficacy and quality. We hear, but it has not been publicly confirmed or denied, that a particular cannabis product has been submitted to our sister organisation, the FDA. We would be very much interested in getting similar applications, but we can't compel such applications; a company has to come to us and apply.

Senator ROBERTS: Thank you. Can you confirm that doctors are reporting substantial toing and froing with the department in an almost endless loop of requests for further documentation of medicinal cannabis prescriptions approved? What is the average time an application takes from first contact with the specialist making a new application to approve that application?

Dr Skerritt: I don't think there'd be data on first contact with the specialist. We will be able to provide you on notice the different systems, where a request has had to go back to the doctor for further information. In terms of time actually spent physically within the department on these applications, the latest figure I have, and again it may be couple of months old—so again we'll provide the up-to-date figure on notice—is 2.7 days.

Senator ROBERTS: I'm aware of that—it's around two days—but apparently it takes months of toing and froing to eventually get it done.

Dr Skerritt: Senator, I think that's a generalisation. There are a number of submissions that are approved within hours on the same day. If a form is fully complete, the submission is considered and approved within a matter of hours.

Senator ROBERTS: Well, you're going to send the data on that.

Dr Skerritt: We'll send you the information. As I've said in this place previously, if, for example, someone writes 'medicinal cannabis' on an application, under law, that's not enough. It would be the same as someone writing 'antibiotic'. You actually have to clarify the product, the dosage and the patient group. Unfortunately, we find that information missing in a proportion of submissions.

Senator ROBERTS: Does the department maintain an audit trail on medicinal cannabis applications that can provide an accurate answer to my previous question?

Dr Skerritt: We can provide an answer on the time it was received and when we sent it back for questions. Unfortunately, some doctors take weeks or months to come back with what would be fairly straightforward requests: 'What product are you actually wanting to prescribe to your patient?' That's not a difficult question. We do have a list of products that

are available in bulk in Australia on the website and we also have recently posted a bibliography of medical reports, medical papers, medical literature, on cannabis for a range of major conditions. So, if someone wants to apply, say, for use of cannabis in particular palliative care applications, they can go to our website and see: 'Yes—here are some studies I can describe where it's been effective in palliative care.' Within the next couple of months, we will also be putting out—and we worked with clinical groups on this—clinical guidance around the use of medicinal cannabis in five major groups of conditions.

Senator ROBERTS: That's coming soon, is it?

Dr Skerritt: That's coming very soon, before Christmas.

Senator ROBERTS: It has been reported to me that it can take, on average, six months for the department to accept an application. Does the department think that requiring such extensive documentation and a substantial investment in their time is a disincentive for doctors to become involved in medicinal cannabis, notwithstanding you—

Dr Skerritt: I think six months is a gross inaccuracy. I have said it's 2.3 or 2.7—I think that was the latest figure—days with us. We have no control over how long a doctor will take to come back and say, 'Actually, it's this particular product I want.' That is out of our hands. We're sending an email straight back saying, 'You actually need to tell us which medicinal cannabis product. We're not, by law, allowed to approve the two words—

Senator ROBERTS: So you're finding some confusion there.

Dr Skerritt: We have also had a number of sessions for doctors around the country, in Sydney, Melbourne, Brisbane and Adelaide, in the last four or five months, and we have involved the patient organisations as well as the broader doctor organisations. We invited the specialty organisations such as palliative care, right through to RACGP, the AMA and others. So there's a significant communication piece. But I do not believe that it is a six-month average period from us receiving an application to typical approval, but we'll provide those figures.

Senator ROBERTS: That data will come. Does the health department have a research function with respect to medicinal cannabis?

Dr Skerritt: The National Health and Medical Research Council, which is a portfolio statutory authority and not a department, to be pedantic, has recently funded some work on medicinal cannabis. These are competitive proposals. There's a centre involving the University of Newcastle that's been recently funded, and the states and territories have also made a very significant investment, particularly New South Wales, in clinical trials of medicinal cannabis products. We took the unusual step of commissioning a review of the evidence because doctors kept saying to us, 'Look, we just don't know what is known and not own about these products. I'm a busy doctor,' as you commented earlier.

So, we undertook to get three universities in Australia, Sydney, New South Wales and Queensland, to do studies of the efficacy or lack of efficacy—these are objective medical studies—of medicinal cannabis in a range of conditions. With that work we were at arm's length to not say, 'You mustn't write that' or 'You must write that.' That work has now gone off for submissions to major global medical journals. It's taken the global literature into account, predominantly English language but including some work that was translated from German—a major review done in Germany. That work is currently before some of the major

medical journals. It will be assessed by peers, as has been the practice for 200 years in medical journals. Those reviews will then be published but, more importantly that work will feed into these reviews of clinical evidence on which we've been working very busily with clinical and patient groups over the last six to eight months. And these clinical guidance documents will be available, as I said, before the end of the year.

Senator ROBERTS: Then I can take it the Health Department is aware of the peer reviewed research showing medical cannabis is effective treatment for pain relief?

Dr Skerritt: That is one of the five areas, and while we do not influence what has been written up, we have met firstly with the group of the three universities I mentioned who have done a study of several hundred reports on pain and spent several months and a team of half a dozen people working on it. We then met with a group of pain specialists, general practitioners and patient groups and discussed their findings from the research. That meeting took place on 13 September in Sydney, at the University of New South Wales. There were 75 people present, I think, give or take 10—there was many dozens—representing the wide range of clinicians from throughout the country.

Senator ROBERTS: So the department would be aware of the peer reviewed research showing that it's also effective in treating the so-called superbug?

Dr Skerritt: There are a lot of research studies that make a lot of claims. I do not believe that there is a general view among the medical community or among medical researchers that cannabis in humans has an effective antimicrobial activity. I'll give you an example. I spent a lot of my life working on putting drugs into test tubes and seeing if anything happened, and in test tube situations drugs can kill bugs. They can also kill growing cancer cells and so forth. It's a massive translation between some preliminary evidence that might show bacteria being killed in a test tube situation through to actually working at clinical levels in a human being. But we do believe these five reviews of major clusters of evidence that have looked at thousands of reports all up are really going to reflect what the state of the art is now. This changes all the time. In 12 months time there might be another 200 studies on cannabis that need to be reflected on and those very recent results brought to the clinicians. We'll have to update this process every year.

Senator ROBERTS: What about the treatment of hepatitis C?

Dr Skerritt: Again, I do not believe it is commonly held, that there is an effective impact in humans in clinical trials for hepatitis C. But again, there may be some initial work at the test tube level.

Senator ROBERTS: What about the peer reviewed research showing medical cannabis is effective in treating sleep disorders, PTSD and Alzheimer's?

Dr Skerritt: There are some studies of the impact on sleep, and these will be covered in the published report. The impacts on sleep are mixed. At high levels, many people are sedated by tetrahydrocannabinol, THC, the psychoactive component in cannabis. But there are also adverse events. High doses of cannabis products do make people sleepy. When they've been tested in groups in palliative care, for example, where good sleep is important for cancer, the studies have actually been mixed as to whether the sleepiness at normal doses is appropriate. So there's some evidence on sleep but there are some studies that say it's not very effective on sleep.

Senator ROBERTS: It mixed, okay. What about PTSD? There are a lot of deaths, and when I say 'lot', I can't quantify it, but a lot of deaths—

Dr Skerritt: The US has an interesting system. Doctors don't have to prescribe medicinal cannabis there; it's actually a notification. It's a bit of a fudge to get around federal prohibition of medicinal cannabis. You don't have to go to a pharmacy to get it. You can go to a cannabis shop and as we have seen on TV they often look a little bit more like a confectionery store sometimes. To cut to the chase: there have been a lot of people in the US and Canada who have claimed PTSD as a significant symptom and requested medicinal cannabis for that purpose. The evidence is mixed when you go to the medical literature. PTSD, to be fair, is a complex disorder; it may have sleep factors, anxiety factors and so forth. There are some studies that suggest that it may provide some relief. There are other studies where there are populations who get cannabis and something else—it's blind, so they don't know what they're getting—where it hasn't been effective. So I don't think it's quite at that stage yet. I say 'yet' because there are more trials underway. I believe the Canadians are doing a big PTSD trial as we speak.

Senator ROBERTS: It's a complex area.

Dr Skerritt: It's a complex area. There's work underway. In a year's time, we may say yes, there's good evidence for PTSD. But I don't think it's quite there yet.

Senator ROBERTS: Some peer reviewed studies have found that medicinal cannabis has completely stopped protein formation in Alzheimer's patients.

Dr Skerritt: You're probably talking about the beta-amyloid protein that forms in the plaques of Alzheimer's patients. There are some studies that have looked at whether the symptoms or perhaps disease progression can be reversed. Again, I don't think there's a view among even the specialist researchers on Alzheimer's that the results are conclusive. It's an area of very active drug development. Again, these are early studies.

Senator ROBERTS: What can the department do to remove the burdensome process that's currently stopping suffering patients from receiving this safe drug? Is there any way of speeding this up?

Dr Skerritt: Remember, this is an unapproved medicine and decisions about seeking to prescribe an unapproved medicine are that of the prescriber in discussion with their patients. The key person here is the prescribing doctor. So the prescribing doctor has to have comfort that these particular products are going to be effective and that standard treatments have been ineffective. What is really happening here is that, unusually, we're investing in assembling the evidence; unusually, we're investing in bringing together doctor and patient groups to discuss this. So we believe awareness will increase significantly. But, at the end of the day, it will come down to a decision by a prescribing doctor as to whether this particular product, or an alternative approach, is the way to go with this patient.

Senator ROBERTS: Would the health department consider appointing an office of medicinal cannabis to curate the research that already exists? And what is the progress of Minister Hunt's promise to investigate and potentially implement the Restart campaign's recommendations?

Dr Skerritt: There is an Office of Drug Control in the department already—and I'm sure you don't want to see bureaucratic proliferation.

Senator ROBERTS: And some cannabis comes under that?

Dr Skerritt: Regulation of the provision, importation and cultivation of that comes under the Office of Drug Control. The Therapeutic Goods Administration has the legal responsibility for access to these unapproved medicines. For better or worse, they both report to me. So they are joined at the hip.

Senator ROBERTS: What is the progress?

Dr Skerritt: Sorry, can you clarify the purpose of that campaign? I might know it by a different name.

Senator ROBERTS: It was introduced by Richard Hopkins, and the Minister said in front of Richard and me that it was the best presentation he'd seen on this topic. It's the Restart campaign. They're advocate that we can change the access just by changing the regulations rather than having a whole new bill. So you're not aware of that?

Dr Skerritt: I'm not aware of that. I don't believe there is any intent by government to change the regulations at this stage.

CHAIR: Do we have any more questions at 4.3?

Prof. Murphy: Senator Dastyari, to save it from going on notice I have some more information on the pertussis question. Both of us were right: ATAGI did provide some advice in March but PBAC considered that and sent it back for further advice in July. So that's why it's still under consideration.

Senator DASTYARI: Thank you. I was going off the public minutes.

Ms Shakespeare: May I also clarify and provide some additional information. Senator, you asked about a brand of medicine called Technivie, and I advised it was awaiting an ARTG number. That's not the case. It's a different brand of medicine from the same company for hep. C, which is waiting for ARTG listing. Technivie has not been listed because the sponsor of the medicine has decided not to list it. But there are several alternatives.

Senator DASTYARI: The question you are taking on notice should provide a table and should be able to answer a lot of that.

Ms Shakespeare: We also have the revenue figure for the year 2015-16—\$694.9 million.

Senator DASTYARI: Was that the savings or the rebate?

Ms Shakespeare: That was the revenue received by government which could be repayments due to differences between published and effective prices and also caps that are negotiated.

Senator DASTYARI: The 694 figure, what's that against?

Ms Shakespeare: Total PBS expenditure that it's against was \$10.8 billion.

Senator DASTYARI: In that year it was roughly an eight per cent discount? Every year is different, is that correct?

Ms Shakespeare: It is different every year.

Senator BROCKMAN: Are we moving on to 4.4, private health insurance?

Senator DASTYARI: I'd like to ask a question on 4.4, because it may save us asking a lot of these questions. I note there is a clear overlap with an inquiry that Senator Griff has set up

which is meeting next Tuesday on private health insurance. I would like to get clarification from the department. Some officials will be appearing last on Tuesday afternoon in Sydney, is that correct?

Ms Shakespeare: I'm not sure of the time, but Tuesday, yes.

Senator DASTYARI: I understand, Chief Medical Officer, you won't be appearing on Tuesday at the Senate inquiry. That's completely understandably, because you're a very busy person.

Prof. Murphy: I'm not intending to.

Senator DASTYARI: I'll ask the questions I have of the Chief Medical Officer now, and that will probably save us asking them twice. I'll also ask things of the minister. There'll be other questions which the department will have time on Tuesday to answer. The most recent announcement by the government allows insurers to discount premiums by two per cent a year, up to 10 per cent for under 30s. Was modelling done on that?

Mr Maskell-Knight: There has been work done by the industry where they examined what they thought the impact on them would be.

Senator DASTYARI: The insurers have done it. Did the government independently do its own assessment? Or was it going off information provided by the insurers?

Mr Maskell-Knight: We have done some work about what we think the impact on participation would be in the context of the rebate estimates and we've come up with a number, if you like, based on current assumptions about behaviour and so on.

Senator DASTYARI: And what is that number?

Mr Maskell-Knight: It's of the order of 50-something thousand net increase in members. Having said that, that's the world as it is now. Industry is much more confident that, with a well-targeted advertising campaign and so on, they can do much better.

Senator DASTYARI: Mr Maskell-Knight, are you coming on Tuesday?

Mr Maskell-Knight: I wouldn't miss it for quids.

Senator DASTYARI: You've said that you've done your own analysis and, separate to that, industry has done its own analysis. Could you to take this on notice: what analysis was done, what steps were taken, what stress testing of the information provided by the insurers was done by the department?

If you're able to provide that, ideally in table form, on Tuesday, if you can table it as part of your opening statement, then I think that will make things move a lot quicker.

I'll move on from there. I have one or two questions for the Chief Medical Officer while he's here today. One aspect of this announcement from the minister, as I read it in the media release, is:

... the Government has agreed to stop insurers from offering benefits for a range of natural therapies ...

Is that your understanding as well, Chief Medical Officer?

Prof. Murphy: Yes, those will not be allowable products for claiming. Insurers will still be able to offer claims under the incentive schemes, but not under the normal extras deductions schemes.

Senator DASTYARI: Okay. This is the bit I'm confused about, so I want to get clarification on the difference between them being able to claim them and them being able to offer them. I read that he has agreed to stop insurers from offering benefits for a range of natural therapies, that they're no longer allowed to be offered.

Prof. Murphy: They're not allowable products under the act, but insurers—and my colleague can explain further—do have an option as an incentive payment in the first year of a policy to offer a range of additional products that aren't listed under the act. But these will not be allowable under the act as extras claimed over the course of the insurance policy.

Senator DASTYARI: So you can't get the rebate off these policies?

Mr Maskell-Knight: Perhaps I can clarify this a bit more. What the government intends to do is make rules under the act saying that insurers cannot pay benefits for these things, which means that they cannot offer insurance products with a promise of paying benefits for them.

Senator DASTYARI: Even if they're not getting the rebate for them?

Mr Maskell-Knight: Regardless of whether they're getting the rebate, yes. But, as the Chief Medical Officer said, it will still be open to them to offer payments in the form of incentives for people to join insurance.

Senator DASTYARI: Again, if you can explain this point to me, Chief Medical Officer: you did a review of a lot of these natural therapies.

Prof. Murphy: My predecessor did, actually.

Senator DASTYARI: They found—I'm paraphrasing what was a much more complex medical review—that some of them were ineffective or effectively were placebos or had some benefits but not necessarily the level of benefits you wanted. They were things like Alexander technique, Buteyko, tai chi, yoga—these kinds of things.

Prof. Murphy: Correct.

Senator DASTYARI: You felt it was an inappropriate use of government money for these things to be rebated. Is that that a broad—

Prof. Murphy: My predecessor was tasked with doing a review to find whether there was evidence of a health benefit of these conditions. The task was not to say that they were of no benefit at all in wellness and wellbeing, but whether there was evidence of a specific health benefit. Now many of these therapies have been introduced without the normal rigour of clinical evidence, so there really isn't any trial evidence. He and an advisory panel, which included members of the natural therapies industry, looked at all of the available published evidence of a health benefit for these techniques and there was no consistent proof in the published literature of a health benefit. That's not to say that if studies were done in the future there may not be.

Senator DASTYARI: That all makes complete sense: when you're applying a rebate, which is the taxpayer dollar, the view is you should set a higher standard and if they can't meet that standard or until they meet that standard—that makes sense completely logical sense, and I think that's a sensible step. The bit that I am not following is the discrepancy between them not getting the rebate, if it's part of their policy, and the minister saying he's

agreed to 'stop insurers from offering the benefit'. Why couldn't they offer the benefit and just not get the rebate for the benefit?

Prof. Murphy: Perhaps my colleague can answer that.

Mr Maskell-Knight: There are a number of answers to that.

Senator DASTYARI: I'll take one.

Mr Maskell-Knight: Well, I think they're all different perspectives. One is that if the government was to say 'you cannot get the premium rebate on natural therapies', insurers would then have to offer a separate natural-therapies-only insurance product. The only people who would buy that would be people who were going to claim for homeopathy or Feldenkrais or Bowen therapy or whatever; therefore, this thing called adverse selection would kick in and insurers would not be able to make money selling that. There would also be a considerable administrative load in them establishing their general treatment policies that covered everything except natural therapies in a separate suite of policies that did. That's one answer. I guess the other answer is that the government believes it's in the interests of the health sector generally that health sector money, whether it's government money or private money, is spent on things that work and, in the absence of that evidence, general premiums should not be diverted to those things either.

Senator DASTYARI: There was one item—again, perhaps it's unfair to be asking Professor Murphy this, because it was his predecessor—your predecessor identified, which was massage therapy. That was included and all the others weren't. The logic for the distinction for all the others made sense—you applied a standard, applied a rule. Why was an exception made for massage therapy?

Mr Maskell-Knight: The Chief Medical Officer's review found there was some limited evidence for massage therapy for symptomatic relief for a number of illnesses.

Senator DASTYARI: Okay. Now I'm just going to read out a bunch of things for you to take on notice for next Tuesday. You may want to have the information available to you then, and we can go through it then. I note at last estimates, in response to a question on notice from Senator Di Natale, you told us the number of policies with exclusions had soared to 2.2 million of a total 5.5 million policies; there's been a 65 per cent increase in exclusionary policies since 2014. I was going to go through the detail of what the government's package does about exclusions, whether there'll be less of them and if there's any action on the out-of-pocket costs that arise from exclusions. I'm just putting that on notice, so we can discuss that on Tuesday. Also, a related issue is excesses. This package increases the maximums from 500 to 750 for singles and 1,000 to 1,500 for couples and/or families. I want to go through the modelling you've done on how many policyholders would have their excesses increase because of this. I assume you did model that?

Mr Maskell-Knight: That's a matter of choice, whether people have their excess increased or not, Senator. We do believe there'll be a small increase in overall participation, because it may attract people into the market that aren't currently there, but we have not done the sums about how many of the existing folk will trade up to a larger excess.

Senator DASTYARI: We'll touch on this, and then we'll move on. Actually, let's do this on Tuesday. We'll do that on Tuesday.

CHAIR: This is a natural point to break. It is almost lunchtime.

Senator DASTYARI: I am literally a minute away. Let me just finish this, and then I'll be done and we can move onto private health insurance. We'll go through that in detail on Tuesday; I'm putting that on notice. Mr Maskell-Knight, I want to put on notice that I want to discuss junk policies and I want to discuss mental health. This is the one last question that I have to ask the minister, and then I believe I'll be done; for the rest, we can deal with the department next week. Minister, private health insurers made \$1.4 billion in net profits last year. Reading through the proposal from the government, there's nothing in the package that addresses excess profits, is there?

Senator Nash: Senator, this not being my area, I'll take that on notice for you.

Senator DASTYARI: Okay.

Senator Nash: My understanding is no, but I'll take it on notice.

Senator DASTYARI: Your understanding is no. Are you aware that the stocks of the listed insurers went up on this announcement?

Senator Nash: I'm not personally.

Senator DASTYARI: We'll be able to talk about that with the department. Minister, the former head of the Private Health Insurance Administration Council says that health insurance holds \$6 billion in excess capital stocks. Is that right?

Senator Nash: I'm not aware of that.

Senator DASTYARI: You might want to take that on notice as something we'll discuss with the department on Tuesday, about the Private Health Insurance Administrative Council, about \$6 billion in excess capital stock and whether or not this government's recent policy puts any pressure or expectation on them to drawdown on that excess.

Senator Nash: Senator, can I just add: our intention to ensure a better deal for consumers is about providing better service and making sure they get the best outcomes, not about curbing company profits.

CHAIR: On that note, Minister, we will suspend for our lunch break. When we resume we will continue with program 4.4: Private Health Insurance.

Proceedings suspended from 12:45 to 13:46

CHAIR: We'll recommence in outcome 4. Senator Dastyari, I believe you have one question on PHI.

Senator DASTYARI: I have one follow-up from a question from earlier. I just note that the review that was conducted around what was and wasn't going to be included was done by your predecessor. You mentioned that the decision was made to include massage therapy because it provided some benefits. There were others that provided some benefits as well that weren't included. I note that I mentioned that the Alexander Technique, Buteyko, tai chi and yoga were found to have some benefit. Why is massage therapy in there? I can understand why some of the more extreme stuff was excluded, but what was the decision about where the line gets drawn? Was massage therapy empirically more or less? How was the decision made?

Mr Maskell-Knight: I'll need to refresh my memory of the review, but my—

Senator DASTYARI: Why don't we do that? If that isn't a matter that the professor will be able to answer now—

Prof Murphy No.

Senator DASTYARI: you can take this on notice for Tuesday. Massage therapy was included because the evidence that you were given was—which you backed up—that it was found to provide some benefit. But there were other items that were found to provide to find some benefit, as I understand, which were the Alexander Technique, Buteyko, tai chi and yoga. Those ones weren't included. I might specifically ask you on Tuesday, Mr Maskell-Knight, about why that distinction was made.

CHAIR: Senator Di Natale, I will point out that we do have a hearing, which I understand you're going to attend, into this particular topic—private health insurance—next Tuesday. I'm not going to stop you questioning; I'm just going to point out that any time we can save here would be very worthwhile as we are running behind schedule.

Senator DI NATALE: Yes. There will obviously be lots of other witnesses at the inquiry. I just want some basic numbers on coverage at the moment. What are we at?

Ms Shakespeare: For the year ending 30 June 2017, there were 11.3 million people covered for hospital treatment.

Senator DI NATALE: Can we do it as percentages?

Ms Shakespeare: That's 46.1 per cent of the population. For general treatment, it was 13.5 million or 55 per cent of the population.

Senator DI NATALE: How does that compare to previously?

Ms Shakespeare: Compared with the year ending 30 June 2016, there were 11.3 million people with hospital cover, which was 47.0 per cent, and 13.4 million people with general treatment cover, 55.7 per cent.

Senator DI NATALE: You've compared year to year, yes?

Ms Shakespeare: That's year ending 30 June.

Senator DI NATALE: That trajectory has been slowly heading south, hasn't it?

Ms Shakespeare: I can give you the figures for the previous years. I don't know that there's a consistent trend.

Senator DI NATALE: All right, perhaps the year before—just percentages is fine.

Ms Shakespeare: In 2015 the percentage was 47.4 for hospital treatment, and for general treatment 55.8 per cent.

Senator DI NATALE: So it's declined by a per cent over the last year. That looks like a trend. Can I ask you about the cost of the rebate?

Ms Shakespeare: Yes.

Senator DI NATALE: Where are we at?

Ms Shakespeare: The estimate for the cost of the rebate in 2017-18 is \$6.4 billion.

Senator DI NATALE: How does that compare to the year previous?

Ms Shakespeare: For 2016-17, estimated actual is \$6.284 billion.

Senator DI NATALE: And the year before that?

Ms Shakespeare: For 2015-16, \$6.162 billion.

Senator DI NATALE: Can I go to complaints? I noticed there was a piece today on an increase in the number of complaints—is that correct?

Ms Shakespeare: I'm aware of the report. That's information about the Private Health Insurance Ombudsman—

Senator DI NATALE: That's right.

Ms Shakespeare: which is in the ombudsman's office, in another portfolio.

Senator DI NATALE: You can't talk to any of the details around the complaints?

Ms Shakespeare: I think it would be difficult for us to talk to the specifics.

Senator DI NATALE: Perhaps let me talk generalities then. The ombudsman has indicated a rise in complaints over the last four years. Do you have any view as to why that's occurred?

Ms Shakespeare: I think you'd probably need to ask the ombudsman for details about the reasons for the complaints.

Senator DI NATALE: You don't have any sense as to why there is an increasing number of complaints? Do you have a sense as to why there's an increasing number of complaints?

Ms Shakespeare: I think we'd need to check with the ombudsman for the reasons for the complaints.

Senator DI NATALE: Do I have this right? The way the model works is that, when you're actually talking about the funding of the complaints mechanism, it's calculated based on the number of existing policies, so, even though complaints might be going up, the actual amount that the private health insurers need to contribute to that complaints mechanism decreases with decreasing coverage—is that right?

Ms Shakespeare: That's not my understanding. My understanding is that the budget for the operations of the ombudsman is set, and then that is distributed between insurers based on their number of members. It's a distribution by members.

Senator DI NATALE: Again citing the report today, because I wasn't aware of this before, the amount insurers were required to contribute to the cost of responding to complaints had fallen. Is that correct?

Ms Shakespeare: The ombudsman's budget, we understand, has gone down a little bit.

Senator DI NATALE: Is that because the levy is actually calculated on the number of existing policies?

Ms Shakespeare: No. Again, I think this is a question best directed to the ombudsman. We understand that the reduction in funding is to do with the consolidation of that function into the broader ombudsman's office.

Senator DI NATALE: You're saying that this report from Sean Parnell today is incorrect because his contention is that it relates very directly to the number of policies that are held?

Ms Shakespeare: The amounts of funding for the ombudsman's office are recovered from insurers, and the amount recovered from each insurer is based on their number of members. But the overall amount doesn't go up and down based on numbers of policyholders. It's the amount of money required for the operations of the ombudsman's office. But I think these are questions you probably need to direct—

Mr Maskell-Knight: The logic of Mr Parnell's article is that the declining membership numbers have led to the declining amount of money. The amount of money is set independently, and then recovered from however many members there are. Unless there is a dramatic decrease within the space of a financial year—and there hasn't been one—then the decline he's talking about is not related to membership numbers.

Senator DI NATALE: I will accept that.

Mr Cormack: I have just one other point to finish that off. In the package of measures that the government introduced, there's an additional funding for the ombudsman of \$4.1 million over the next four years. That's to expand the role of PHIO to provide for additional inspection officers; to improve the website so that consumers have better access; to assist with introducing new minimum data set requirements and making the product data that insurers provide to the website available in different formats; to make the regulatory requirements for information provision more flexible; and to establish a committee to consider best practice models. Notwithstanding the media reportage, the government has allocated an additional \$4.1 million to strengthen the role of the ombudsman.

Senator DI NATALE: I will move on. Thank you for that. I'm interested in the recent announcement that young people are going to receive a discount of two per cent per year if they join before they're 30, up to 10 per cent, and then phased out after 40. It's fair to say that the rationale here is that young, healthy people improve the risk pool and increase the number of nonusers. Is that part of the rationale for what we're talking about?

Mr Maskell-Knight: Correct.

Senator DI NATALE: What we're basically doing—and this is extrapolating from what you said—is trying to get young people in to purchase a product that they hope that they won't actually use.

Mr Maskell-Knight: I think everyone purchasing health insurance hopes they're not going to be using it.

Senator DI NATALE: They're less likely to use it if they're young, fit and healthy, aren't they?

Mr Maskell-Knight: True.

Senator DI NATALE: Stephen Duckett, former secretary of Health, made the statement: This is expected to attract some young, healthy people to take up insurance and so improve the insurance "risk pool"—by increasing the number of non-users.

Mr Maskell-Knight: Absolutely.

Senator DI NATALE: Would it be fair to say that having an increased number of young people is a way of providing a benefit to those people who are older, sicker and more likely to use the policy?

Mr Maskell-Knight: That's correct. The whole Australian system of community rating revolves around the fact that, until you're 55 or thereabouts, it is actuarially sound not to purchase health insurance. To overcome that inherent disincentive, the former government introduced the Lifetime Health Cover arrangements.

Senator DI NATALE: But, if you're a young, fit, healthy person, why would you bother taking it out? If the express intent is, 'We want you to take this policy out because you're

unlikely to use it, certainly much less likely than an older person,' why wouldn't you just wait until you're older and more likely to have to make use of the policy?

Mr Cormack: There are other things at play here. There's Lifetime Health Cover—

Senator DI NATALE: I understand that.

Mr Cormack: so you're actually getting people in at an earlier age and they're more likely to—

Senator DI NATALE: But that's been in play for a long time.

Mr Cormack: But it's actually building on a very successful policy measure already, and also encouraging people to remain in the health insurance system for as long as possible—

Senator DI NATALE: They already are. They've got Medicare; it's a national health insurance system.

Mr Cormack: I think that's—

Senator DI NATALE: But why are we encouraging them to take up—

Mr Cormack: It's government policy.

Senator DI NATALE: I'm just thinking as a young person. If you're saying explicitly, 'This is to try to get you in so you can help reduce the premiums of older people who need it more,' why would a younger person take it up?

Mr Cormack: I think the government's policy is very clear on private health insurance.

Senator DI NATALE: I know.

Mr Cormack: They encourage people to make provision for their own health and to give themselves choice. There are benefits to having private health insurance. Beyond that, I think you're asking us a policy question.

Senator DI NATALE: I'm asking, basically, a question that I think most young people are asking right now: 'Why would I bother?—particularly given that the incentive is designed to get me in to try and help a whole bunch of other people.' But that's not something I'll get you to comment on. In the recent review, you didn't address the issue of junk policies. Can I ask why that wasn't addressed?

Mr Maskell-Knight: That was a decision of government, at the end of the day. I don't think the department's ever used the term 'junk policies'. I think it is commonly used to refer to products with relatively low costs and relatively low coverage. As we've just been discussing, those products contribute to the risk pool as a whole and to cross-subsidising older and sicker members, who do make use of health insurance. In making the decision not to do anything about these products, I think the government had regard to the fact that expanding the scope of current low-cost, low-scope products would lead to very significant premium increases for those products, which would lead to membership reductions, which would lead to premiums for older and sicker people going up, which would lead to membership decline overall and more pressure on public hospitals.

CHAIR: Has there been any quantification of the potential increase? Have you done any work on that, or has anybody that you know of?

Mr Maskell-Knight: We haven't done work recently on that. Certainly, if you look at the membership numbers through the 1990s, you can see exactly that sort of decline going on.

The percentage of the population covered by health insurance fell from about 45 per cent to 30 per cent, yet the number of older people with health insurance went up. And that was accompanied, towards the end of that period, with premium increases of 10, 15, 20 per cent.

CHAIR: Thank you.

Senator DI NATALE: It sounds like a business model that might be broken. The prosthesis reductions—how much are you expecting that to save?

Ms Shakespeare: Over the course of the agreement with the Medical Technology Association of Australia, the benefit reductions over four years are a bit over \$1 billion.

Senator DI NATALE: As part of that arrangement, have you removed the requirement for the two years of clinical data?

Ms Shakespeare: The agreement includes—I'll just need to look up the date—from, I think, a period in 2019 that there will be no blanket requirement, for new prostheses applications, for two years worth of clinical data. What there will be is fit-for-purpose assessment, based on the type of application that's coming in, and there are other commitments in the agreement to develop fit-for-purpose assessment pathways for different types of devices. But, yes, the two-year blanket clinical data will be removed.

Senator DI NATALE: I suppose the concern that people will have is that you've got a new prosthesis coming on the market and there's not going to be any requirement to keep clinical information about the performance of that prosthesis. Is that true? In some instances, we're going to see a brand-new device where there's no requirement to keep that clinical data?

Ms Shakespeare: No. The expert committee, the Prostheses List Advisory Committee, will determine what appropriate level of data they require to determine whether a new type of device seeking listing on the Prostheses List is comparatively effective, comparatively cost effective and comparatively safe.

Senator DI NATALE: If it's a new device, how do you make a judgement about reducing the two years of clinical data?

Ms Shakespeare: It may actually be increased.

Senator DI NATALE: But it may actually be decreased.

Ms Shakespeare: We rely on our experts on the Prostheses List Advisory Committee.

Senator DI NATALE: I'm asking you: on what basis will experts decide you don't have to keep two years of clinical data? What are the factors that would mean you don't have to keep that two years of clinical data?

Ms Shakespeare: The experts will look at the type of device, whether or not it's a novel device, whether it's been assessed previously and whether it has other reasonably similar comparatives in working out how much evidence of effectiveness they will want to see. That's the concept of fit-for-purpose health technology assessment which is introduced under the agreement.

Senator DI NATALE: Isn't there a concern that you're going to open up greater risk by removing the two-year clinical data requirement?

Ms Shakespeare: No. As I said—

Senator DI NATALE: There's no risk to that?

Ms Shakespeare: the evidence will be fit for purpose and, in some cases—there are all sorts of different products on the prostheses lists; some are screws, staples, up to very complex cardiac devices—there needs to be, rather than one requirement around evidence, fit-for-purpose guidelines around what's required by sponsors for health-technology assessment of those devices.

Senator DI NATALE: And the superior clinical supportive incentive was removed.

Ms Shakespeare: That will be phased out under the agreement.

Senator DI NATALE: Why is that?

Ms Shakespeare: The review from the prostheses list committee is that while there are some devices that have clear clinical superiority, based on the length of time they have collected data for, over time it's become less valuable because more and more devices are getting to the same point, in terms of the length of evidence they have around, for instance, in a hip replacement time to revision. So the superior clinical performance suffix will remain but the premium benefit will be phased out.

Senator DI NATALE: What you're saying is they're all so good we don't need it. Is that summarising—

Ms Shakespeare: I think that was the view of the Prostheses List Advisory Committee, that there are more and more devices meeting the current requirements for superior clinical performance. Effectively, it was not doing anything other than increasing the benefits for these categories of device.

Senator DI NATALE: I probably have enough on private health insurance, Chair, so I am happy to move on to dental unless there's—

CHAIR: Senator Griff, you didn't have anything in private health insurance. Senator Smith, as you don't either, we'll move on to outcome 4.6.

Senator DI NATALE: What is the uptake of the child dental benefit schedule?

Mr Cormack: Since commencement, 2,095,677 children have utilised the program. In 2017 that number is 859,714 children; that's to September.

Senator DI NATALE: What's that as a proportion of eligible children?

Mr Cormack: It's 34.6.

Senator DI NATALE: What was the raw number?

Mr Cormack: The 34.6 refers to the 2016 year. Let me give you those figures first, then I'll come back to the one I just gave you. In 2016 it was 1,036,920 children out of, basically, 2.9 million, equating to 34.6 per cent. So this year, and I don't have up-to-date figures for the number of notified eligibles, we can say that 859,714 children have utilised the program in 2017.

Senator DI NATALE: How is that tracking compared to the same time—

Mr Cormack: It's looking better.

Senator DI NATALE: How much better?

Mr Cormack: I'll have to do the precise maths, but we are basically—

Senator DI NATALE: What was the raw number back then?

Mr Cormack: The raw number for the full year in 2016—

Senator DI NATALE: But up to September?

Mr Cormack: I don't have the September-to-September comparisons in front of me.

Senator DI NATALE: Right. But you're confident that 800,000 number is higher than it was at the same time last year.

Mr Cormack: We believe that it is, but we will certainly need to take that on notice; we will certainly do that. Also, there's been a much higher level of awareness since the settling of the policy and, as you're probably aware, a number of the corporate dental companies have been very actively promoting the scheme since it was settled.

Senator DI NATALE: Are there no more fact sheets telling people they can't use the program?

Mr Cormack: They're artefacts of the past, Senator, as you know.

Senator DI NATALE: Yes, good! What is the government doing specifically to promote it?

Mr Cormack: We have our normal arrangement with the Department of Human Services, where we do an annual mailout, which is the main way that we would make people aware of it. We have also—

Senator DI NATALE: Just to be clear, you just send a letter, what, at the start of the financial year or 1 January?

Mr Cormack: Beginning of the calendar year.

Senator DI NATALE: To anybody who's eligible?

Mr Cormack: That's right.

Senator DI NATALE: And it's a specific letter about the—

Mr Cormack: Yes, that's right. That's as direct as you can get.

Senator DI NATALE: Yes.

Mr Cormack: We have also done some social media campaigning as well to raise awareness of the scheme, in August 2017, and we'll continue to do that until the end of November 2017. We'll evaluate that to just to see whether that's lifting the level of awareness.

Senator DI NATALE: I saw those Facebook squares, I think, weren't they?

Ms Cole: Their little teeth!

Senator DI NATALE: Yes. Not sure about your digital department, but anyway! How are you targeting the Facebook squares? Where are they going?

Ms Cole: At the moment we're just doing a small preliminary trial. It's essentially on our Facebook and we're reposting to Human Services and the ADA. The Australian Dental Association is going to be reposting. We have about twice the normal engagement rate for our Facebook posts, so it's reasonably popular for a departmental campaign.

Senator DI NATALE: What does twice the level—is it like what we heard from the TGA—from next to nothing to just a bit better than nothing?

Ms Cole: Close, yes.

Senator DI NATALE: Pretty much.

Ms Cole: Normally, you'd get about two per cent click-throughs on the department's Facebook type posts. This time we're getting around four per cent.

Senator DI NATALE: Are you evaluating the effectiveness of that campaign?

Ms Cole: Yes. It's a trial, so we intend to evaluate it and then consider what other low-cost activities we can use to supplement that, in addition to the letters provided by DHS.

Senator DI NATALE: Okay. Can I ask you about the status of the National Partnership Agreement for public dental services?

Mr Cormack: Yes. As you're aware, \$242.5 million was allocated to an NPA with the states, and that covers the period 1 January 2017 to 30 June 2019. That agreement is expected to provide services to around 400,000.

Senator DI NATALE: Sorry, I missed the number at the start. Would you mind repeating that?

Mr Cormack: It's \$242.5 million.

Senator DI NATALE: For what period?

Mr Cormack: From January 2017 to 30 June 2019.

Senator DI NATALE: A 2.5 year period.

Mr Cormack: That's right. And that's because there was a half-year, effectively, an extension of the previous NPA offered to the states. I think it was \$77.4 million for the period July 2016 to December 2016. So—

Senator DI NATALE: What is that per year?

Mr Cormack: It's about 110, I think. I'll get you a precise figure on that. Around about that per annum over the three years.

Senator DI NATALE: Isn't that a cut from where you were in 2016 and 2017—what was projected? It was \$128 million, wasn't it?

Mr Cormack: No, the previous National Partnership Agreement was \$155 million for a year.

Senator DI NATALE: Yes, and it was cut to 128.

Mr Cormack: It is a lesser amount than—

Senator DI NATALE: So has been another cut?

Mr Cormack: No, there hasn't been another cut. When the dental arrangements were settled—

Senator DI NATALE: Okay. So we have gone from 155 per year to 128 per year to, now, 110 per year.

Mr Cormack: I'm not sure where you are getting the 128 per year.

Senator DI NATALE: It was cut from 155 down to 128—was supposed to be in the calendar 2017.

Mr Cormack: We'll double-check your figuring, but I'm confirming there's been no further change to what was announced earlier. And, yes, the funding on a per-year basis is lower. That was announced when the government settled its arrangements. We're finalising

agreements with a number of jurisdictions. We have a couple of them formally signed up—South Australia and Tasmania—and we'll be finalising arrangements with the other states.

Senator DI NATALE: We've had a significant reduction from \$155 million originally, which itself was a reduction, down to \$110 million per year now, is that correct?

Mr Cormack: We'll get a calculator out in a minute

Senator DI NATALE: I just want to compare apples with apples.

Mr Cormack: The figure is \$242.5 million.

Senator DI NATALE: But that's over 2½ years, yes?

Mr Cormack: \$242.5 million plus \$54 million on top of that for the first six months of the three-year period. That's \$297 million for that three-year period.

Senator DI NATALE: So you'll give me that per annum?

Mr Cormack: Yes, we'll get you that before we finish today.

Senator DI NATALE: Given there has been another reduction in the funding for public dental, what's that doing to public dental waiting lists? Do you have any data?

Mr Cormack: We have some data on waiting lists. The current weighted average to December 2016 is 12.05 months.

Senator DI NATALE: That's a national figure, is it?

Mr Cormack: That's a national figure.

Senator DI NATALE: Do you have state-by-state breakdowns?

Mr Cormack: Yes, I can give you state by state.

Senator DI NATALE: Can you give me each state?

Mr Cormack: Yes. 31 December 2016: New South Wales, 14.2; Victoria—

Senator DI NATALE: This is the average waiting list, yes?

Mr Cormack: This is the national average, yes.

Senator DI NATALE: The state average?

Mr Cormack: Yes, I'm working backwards from the national average to the state average. 14.2—

Senator DI NATALE: In New South Wales?

Mr Cormack: Yes. Victoria, 16.01; Queensland, 5.6; Western Australia, 2.5; South Australia, 14.7; Tasmania, 9.4; ACT, 5.95; and NT, this is showing 45.

Senator DI NATALE: 45?

Mr Cormack: 45.7. NT has historically been higher.

Senator DI NATALE: So there's an almost four-year waiting list to see a public dentist in the NT?

Mr Cormack: Those are the waiting times provided to us by the NT.

Senator DI NATALE: Four years, and we're still cutting funding for public dental care?

Mr Cormack: The government has determined the funding arrangements, and there has been no change since that last determination.

Senator DI NATALE: How do they compare to the previous year?

Mr Cormack: I'll give you the figures for the previous year. 31 December 2015: New South Wales, 12.92; Victoria, 12.77; Queensland, 7.32; Western Australia, 4.3; South Australia, 12.45; Tasmania, 12.2; ACT, 5.56; NT, 30.8. I think the point to make there is that this is a contribution to a state government responsibility. You can also see through the year-on-year variations in those waiting times that a number of them go down, a number of them go up. I think there's an issue of—

Senator DI NATALE: I'm looking at the big states: New South Wales has gone up by a couple of months, Victoria up by three, four months. The NT has gone up by over a year. They're big increases in waiting times.

Mr Cormack: In Queensland, Western Australia—

Senator DI NATALE: It's pretty hard to escape the fact that we've seen cuts in the Commonwealth contribution and we're seeing corresponding increases in waiting times.

Mr Cormack: I'm not disputing there has been a reduction in Commonwealth funding, but I'm also saying this is not an area of sole Commonwealth responsibility; this is an area predominantly of state government funding.

Senator DI NATALE: No.

Mr Cormack: They're primarily responsible for public dental services and always have been.

Senator DI NATALE: Yes, but if the Commonwealth's pulling funding out of dental and waiting lists are going up, it's a pretty reasonable conclusion to draw that the Commonwealth's cuts in funding are having a contribution to waiting times for dentists.

Mr Cormack: You could say that in some states, but you could say the opposite in other states. That's what the figures say.

Senator DI NATALE: Overall the figures show a significant increase in waiting times.

Mr Cormack: Overall, the figures do show an increase in waiting times, but there is variation from state to state. And the other thing is that the states, under the arrangements, continue to have access to the child dental benefit scheme for their own public dental services. That's a demand-driven program, and the state and territory governments are able to fully access it. A number of the states have chosen not to access that through their public services.

Senator DI NATALE: If you're an adult, you can't access it, and—

Mr Cormack: But the states are able to access additional revenue through the CDBS for their overall public dental—

Senator DI NATALE: Not for adults, though?

Mr Cormack: No, for their overall public dental services.

Senator DI NATALE: That's not a very positive story. I'm probably done.

ACTING CHAIR: Senator Griff, I understand you have some questions.

Senator GRIFF: On 4.7.

ACTING CHAIR: Does anybody object to us going to 4.7? In other words, does anybody have any other questions before we go to 4.7?

Senator SINGH: No objection.

Senator GRIFF: I'd like, in this particular section, to look at medical transparency and accountability generally. I asked the minister via question time—in fact, Senator Nash in September—what the government was doing to assist consumers to make informed choices through publicly available performance data. Senator Nash, representing the minister, said the minister 'has already been working with the royal college of surgeons, health stakeholders, and the Department of Health in examining options to improve the information available to assist consumers in making informed decisions about their health care, including the development of a transparency model'. Are you able to detail what work has been done so far and what options have been examined?

Ms Shakespeare: In fact, one of the reforms announced around private health insurance will have some impact here. There will be an expert working group to look at costs to patients and better information that will help patients inform their decisions around accessing privately insured services. That would be one piece of work. There's also other work that we are undertaking with various groups that are publishing information about performance and outcomes and billing information. That's from different medical groups.

Senator GRIFF: Which groups are you referring to?

Ms Shakespeare: There is a range of groups that provide information at the moment. The Royal Australasian College of Surgeons is one. There's also some information from websites that have been arranged by some private health insurers. Bupa Australia is involved. There's also Medibank Private, and I think HCF is involved on another website.

Senator GRIFF: Billing information is not outcomes. It's not enabling a potential patient to be able to see the performance of a hospital or the performance of a particular surgery type, with a surgeon, and so on. That is really what is lacking. Are you doing any work in that particular area to make that information available to the public?

Ms Shakespeare: There has been work in the past, and I'm not familiar with the detail—

Senator GRIFF: So no current work?

Ms Shakespeare: around hospital performance. We have discussions with medical groups about their views on releasing outcomes measures. There's also work happening through discussions with the states and territories around patient reported outcome measures at the moment. So there's work happening on a range of fronts, Senator.

Senator GRIFF: However, it's generalised; it's not related to a specific doctor, for instance, or certain procedures. A lot of this information is available in other countries, but not in Australia.

Ms Shakespeare: Again, there is different information available in Australia as well, if you're talking about procedures, and we have information about joint-replacement procedures.

Senator GRIFF: It's true, but a potential patient is not able to see whether Dr X versus Dr Y, or a particular clinic, is performing better than another clinic. That's not available in Australia, but it's available, for instance, in the UK. Is that not of concern to you? You're not looking at having a similar model, like what they do actually have in the UK, for instance?

Ms Shakespeare: As I've indicated, we are having discussions on a range of fronts about increasing the information that is available to patients.

Senator GRIFF: The minister would be aware of this, because I asked a similar question in question time: if we have a look at the publication, or the lack of publication, of IVF success rates—from the 2014 *ANZARD* report, live-birth rates vary from 9 per cent to 24 per cent between clinics for fresh cycles. This information is not available on a clinic-by-clinic basis, so it's not transparent to consumers. I also note that the ACCC reviewed the claims made by some clinics that are advertising what their rates are, and forced a number to change the way they publish their success rates on their websites. Is the department actually doing any work to investigate the possibility of publishing nationally consistent data for outcomes for all clinics rather than leaving clinics to voluntarily publish their own selective data?

Ms Shakespeare: We are having discussions and doing work with the Fertility Society of Australia, which owns that particular information and database that you mentioned. Yes, we are working with them.

Senator GRIFF: You're working with them to achieve what?

Ms Shakespeare: To see whether or not more information can be provided to the public about the success rates of particular clinics.

Senator GRIFF: So, you've discussed with them the option of being able to publish them on a clinic-by-clinic basis?

Ms Shakespeare: We are discussing that; it's an ongoing piece of work.

Senator GRIFF: When do you expect that to be finalised?

Ms Shakespeare: I'm afraid I couldn't say. Perhaps I can take that on notice.

Senator GRIFF: That would be fantastic, thank you. There's actually quite a lot of industry opposition to publicising clinic data, with claims it's often too difficult to do. Yet, as I mentioned before, in the UK and also in the US they do it quite well, by reporting success rates of each clinic with explanatory notes. Are you aware of the reporting that these other countries are making publicly available?

Ms Shakespeare: Not personally, but I'm sure that I have people in the department that would be very much across it.

Senator GRIFF: At this stage, you're not looking to do anything similar?

Ms Shakespeare: As I said, we're in discussions with the Fertility Society of Australia to look at what information can be publicly provided to better inform potential patients of IVF clinics.

Senator GRIFF: What, if anything, is the department doing or able to do about outlier clinics that perform poorly?

Ms Shakespeare: If there are concerns about the standard of clinical practice being provided by doctors working at those clinics or, in some cases, the clinics themselves, that's something that our compliance area can investigate.

Mr Cotterell: I'm not aware that we've had reports of substandard practice.

Senator GRIFF: *The Daily Telegraph* recently ran a story about an IVF clinic that has a scheme where it pays doctors incentives to perform more IVF cycles. Are you aware of this practice? Do you have concerns with it?

Ms Shakespeare: We are aware, and that has been referred to the MBS Review Taskforce to look at any practises around incentives to bill by numbers of patients rather than by what is clinically required service. For the purposes of Medicare, doctors are only able to claim for clinically relevant services. If there is evidence that providers are not complying with those, then that can be investigated by our compliance area. However, the broader issues around, I suppose, employment conditions and the impact that may have on Medicare billing, that's something that's been referred to the MBS Review Taskforce and has already been considered at some meetings of that task force.

Senator GRIFF: With Medicare data, are you able to track cycles and live-birth rates through Medicare?

Ms Shakespeare: The Medicare data does not include live-birth rates. We would collect information on funded services. So there's no requirement.

Senator GRIFF: It doesn't track cycles either.

Ms Shakespeare: I'd just need to check that. Yes, the data does track cycles.

Senator GRIFF: Just following on with similar questions in another area, I'd like to refer to the Medicines Australia code requiring compulsory reporting of doctor and nurse practitioner benefits, gifts and the likes that are provided by pharmaceutical companies. My understanding is that this is not consolidated in one location and instead it's actually housed on individual pharmaceutical company websites, which means it's, of course, difficult to track individual participation in these benefits, if you like, that the pharmaceutical companies are offering. In the interests of public transparency, has the department given any consideration to collecting this information and providing a register of benefits that big pharma provides to doctors, nurses and allied professionals?

Ms Shakespeare: The code of conduct belongs to Medicines Australia, so Medicines Australia is already undertaking regulatory work around making sure that the code is enforced. There's a compliance mechanism that they run, in that people can make complaints to them and they investigate those. There are transparency reporting requirements. Given that this is a function that's already being undertaken by industry, it's not something the government is looking to set up in competition with.

Senator GRIFF: However, aren't you, as a department, interested. If you have certain groups, certain practitioners, that are receiving a significant amount of gifts and other incentives, would that not be of concern to you?

Ms Shakespeare: We do certainly have a look at the information that is published under the Medicines Australia code.

Senator GRIFF: However, as it's currently published under each pharmaceutical company, it's not collected and available on one site. Are you reviewing it by looking at all of the pharmaceutical sites? Is that the way that you're reviewing and checking the situation?

Ms Shakespeare: There's generally aggregated information that is put out by Medicines Australia.

Senator GRIFF: I recently visited the Australian Orthopaedic Association's annual scientific meeting, and the largesse provided to surgeons was really quite astounding. In fact, it was a very impressive few days. There isn't a similar code for prosthetic device companies.

Could the department either work with manufacturers on this or undertake that for prosthetic devices as well so there is something similar, given the size of that market?

Ms Shakespeare: I think it's something we could have discussions with them about. We have a lot of reform work happening at the moment with our prostheses private health insurance funding arrangements, but I understand that there are also discussions within industry about whether or not an industry-based set of arrangements could be set up around devices.

Senator GRIFF: You mentioned you could have discussions with them. Will you have discussions with them? Will you consider this item?

Ms Shakespeare: It's something we would be willing to discuss with companies if that was considered necessary.

Senator GRIFF: I think it's very necessary, given the size of that industry and the cost to the health budget.

Ms Shakespeare: I'm sorry, senator?

Senator GRIFF: I think it's very necessary to actually have that information, given the amount of money that's actually expended in that particular category.

Ms Shakespeare: We'd be happy to raise it with them.

Senator GRIFF: Great. Thank you.

[14:33]

ACTING CHAIR: I understand there are no more questions in this outcome area, so I propose that we move on to outcome 2. We're starting with health workforce. Senator Watts, is that where you were starting—workforce?

Senator WATT: No, my question comes up in 2.4.

ACTING CHAIR: Let's do 3 and 4 to try to keep the order. So I'll go to Senator Watt. We want to start with 2.4.

Senator WATT: Welcome, Ms Beauchamp, and congratulations on your appointment. My first round of questions relate to the National Cancer Screening Register. Ms Beauchamp, while your officials are coming to the table, the National Cancer Screening Register is something I have raised on a number of occasions now going back to the inquiry we had about the bill to introduce this register in the second half of last year, and I've got an ongoing interest in its implementation. When we talked about this at the budget estimates, I think what we were told was that the renewed National Cervical Screening Program was due to be implemented on 1 May this year and that's certainly what we were told at the Senate inquiry late last year. But that deadline was missed and the program was delayed because the National Cancer Screening Register wasn't ready. We were told at last budget estimates that the government delayed the start date to 1 December this year so that, in itself, would be a seven-month delay. How confident are you that the Cervical Screening Program and register will go live on 1 December?

Mr Madden: The plans for cervical renewal and for the first components of the register are locked in for 1 December 2017.

Senator WATT: What exactly is locked in?

Mr Madden: The implementation of cervical renewal.

Senator WATT: Cervical renewal?

Mr Madden: Yes. The new screening to move from pap tests to HPV testing

Senator WATT: A system to remind people to come and get tested?

Mr Madden: And a register. The first stage of that will receive electronic reports from path labs for HPV, LBC and any residual pap smears that started before 1 December and continued post 1 December. Then in January, before the first reminder period comes or the first follow-ups for any high grade high risk, which is eight weeks after, the complete system will be in place for those reminders, invitations and renewals and follow-ups to happen as well.

Senator WATT: When would the complete system be up and running?

Mr Madden: We'll have the complete system there from the middle of January and we'll have the state and territory register information—all the history—there by the first week of March 2018.

Senator WATT: The deadlines we were previously given being 1 December, and the one before that being 1 May, is the appropriate comparison 1 March now, with the system fully and up and running with all of the data that's required?

Mr Madden: I think the 1 May date was the commencement of the cervical renewal program.

Senator WATT: Yes.

Mr Madden: That was 1 May. The equivalent in this scheme is the commencement of the cervical renewal on 1 December.

Senator WATT: You're confident then, and you can guarantee, that the cervical screening program will be up and running on 1 December this year?

Mr Madden: Yes.

Senator WATT: Does that also mean that the register will be up and running on 1 December this year?

Mr Madden: That is certainly the intention. We have high confidence it will be there on 1 December. Bearing in mind this is a technology and there may be risks, at this stage the confidence that the register will be there to support this from 1 December is very high. It's tracking according to the plans at this stage.

Senator WATT: But then you said that it would take until mid-January—I think the way you put it was for the complete system to be up and running. So what does that mean? What happens after 1 December but by mid-January?

Mr Madden: From 1 December we'll have a register to receive pathology reports for all cervical screening; that's a single national register to receive all reports. We'll have a contact centre to take calls from health professionals, program managers and other stakeholders. We'll be able to receive clinical results from pathology labs across the country. We'll be able to report HPV positivity rates for pathology labs and government forums. We'll have a static website to allow health professionals and participants to access the information about the

program; and a solution that is most compliant with Australian government security standards, privacy requirements and those things. From January we will have—

Senator WATT: Just before you move on, are you moving to the things that will be done by March?

Mr Madden: That was all of December. From middle of January, we'll have the whole of the register solution which will connect the register, its telephone system, the reporting, the mail-house functions, fax services, identity and address validation functions, analytical capabilities to assess the results that are received to put people on the right clinical pathways, and the ability to directly match clinical results from pathology labs to the records—make them available as complete histories for participants. I should have mentioned: from 1 December, states and territories will continue to furnish historical cervical screening information about the participants until they transition from the middle of January. From the middle of January, issuing those histories will come completely out of the national register—issuing invitations and follow-up letters in line with the protocols of action for the cervical renewal program; call centres to address all inquiries and updates for the register participants as well as doctors and other health professionals; and nine cervical screening reports, which will assist states, territories and the Commonwealth understand the efficacy of what the cervical screening program is doing.

Senator WATT: That's actually quite a lot of additional components that will be implemented between 1 December and mid-January.

Mr Madden: Yes.

Senator WATT: That really means, doesn't it, that the register and the program won't really be up and running on 1 December; it will take at least until mid-January. What else will happen after January but by 1 March?

Mr Madden: I need to split the function and the outcome of the renewal of the National Cervical Screening Program from the register. The renewal of the National Cervical Screening Program will be completely live on 1 December 2017. That will allow GPs and other health professionals taking cervical screening samples to send them to pathology labs, and they'll be taken through a HPV testing process. From 1 December we'll have Medicare fees, the Medicare schedule descriptions and the ability for doctors to take those samples, send them to labs, and they'll be subjected to a HPV—rather than a pap—test. All of that will be available nationally from 1 December. Bearing in mind that the primary pathway for cervical screening and the primary care route is actually between the patient, the doctor and the pathology lab.

The cervical screening register is a secondary issue, which keeps a check of, and provides a safety net, to make sure people are invited and are regularly reminded that cervical screening is a good thing, when the time is up. But it is also so that those who have high-risk or high-grade or unsatisfactory results are followed up in accordance with the protocols of action. Whether you should be referred to a specialist, go for a 12-month re-examination or go for five years are the things that are determined through that program.

Senator WATT: And they won't be happening until?

Mr Madden: None of those follow-up actions happen until we hit 12 weeks anyway. So we'll have enough for the renewal of the cervical screening program. We'll actually go live on

1 December completely, in the hands of general practitioners, specialist path labs and all the specialists that are in that space, and for the women in the community. Those follow-up functions will be in the system and available from the middle of January, and any high-grade results will be acted upon from 1 December. So those follow-ups will be available from 1 December.

Senator WATT: I think I'm right in saying that, when we've asked you and other officials about this previously, it's never been made clear that, while there'd be some aspects done by 1 December, there'd other bits that might take a bit longer and other bits a bit longer still. For instance, I have just gone back and had a look at your evidence at the last estimates where you said:

We are focusing completely on supporting the cervical renewal from 1 December—
this year—

with the register to support it first.

You also said:

At this stage, we are tracking towards the December date for cervical renewal and for the new register to support that as well.

My interpretation of what you've been saying today is that we won't have the register operational fully by 1 December. Is that correct?

Mr Madden: We will have the register operational to support the cervical renewal from 1 December completely. The further functions will be scaled in later. We previously had a transition plan to transition states and territories first. We've shifted that into the second part of the scheme. So the functions to support the cervical renewal program will all be there from 1 December.

Senator WATT: So it will be able to do some things by 1 December, but there will be other important parts of this register and this program that won't be delivered until 1 March.

Mr Madden: Till the middle of January.

Senator WATT: But then it will take until 1 March for additional—

Mr Madden: The fully functional register from the middle of January; transition of states and territories, historic data, from the middle of January; completed by the first week of March—so the full functionality of the register is there from the middle of January.

Senator WATT: In what sense do you say that the register is fully operational for cervical screening if it can't send follow-ups until later?

Mr Madden: From day one of cervical renewal program we need to be able to receive the pathology results for HPV, liquid based cytology and Pap, to the extent that they'll continue to exist. We need to be able to store, retrieve and report on those. We'll be able to do that. The first follow-up actions happen in an eight-week period where we will follow up those with a positive, and that follow-up action will be available from 1 December. The next follow-up actions that are required are at 12 weeks, between 12 and 16 weeks. We'll have the full facility in place within 12 to 16 weeks of 1 December. The cervical renewal program will be completely supported by the register.

Ms Beauchamp: The most important thing for women is that they'll have access to this new test from 1 December. Assimilating eight different historical records over that period from 1 December, we do have to absolutely make sure we do that well.

Senator WATT: Sure.

Ms Beauchamp: But I guess for all women to be reassured that we're going to have a fantastic new test available from 1 December.

Senator WATT: I've got no doubt that it's a major task, and I've always acknowledged that. My concern is with the deadlines being missed and with the government—not necessarily you—having raised expectations as to when this would be available. Because of the difficulty in this task, deadlines keep being missed, and this very important system isn't being rolled out in line with those deadlines.

Ms Beauchamp: I guess the reason why we're expressing a high level of confidence is that both Paul and I are meeting with our contractors on a weekly basis, including the head of Telstra, to make sure we've got everything absolutely locked in, to make sure this is operational from 1 December. When you get to this stage of a project, particularly an ICT project involving the states and territories and a number of people in the private sector—the path labs and the like—it probably has been a complex project from early days. But there's a system there now, it's being tested and we're given a high level of confidence in being operational from 1 December.

Senator WATT: At the last estimates, we discussed a number of milestones that needed to be met in order to go live on 1 December. Can we just run through them and see where they're at? These were the things that needed to happen before 1 December—what you termed 'system available'. Has that been achieved?

Mr Madden: Yes, the system is available.

Senator WATT: When did it become available?

Mr Madden: It's been available and been tested since the middle of July.

Senator WATT: You said that the system being tested would happen between July and August.

Mr Madden: The system testing happened between July and August and continued into September. The completion of the full system integration testing was completed in the second week of October.

Senator WATT: So, all up, it was done by about 2 October? That slipped a little bit from the August expectation.

Mr Madden: We do have a detailed plan. The testing of this system will continue all the way up until the week before the system is commissioned into production, if that's the right term. We will continue to test components of the system all the way through, including migration of data, and we have pathology labs that are testing their connections and the ability to lodge pathology results with a register from here through until 1 December as well.

Senator WATT: The next one was having the system ticked off by users. You said that this had to happen in mid-September. Did that happen on schedule?

Mr Madden: We have had user based testing. I don't have the exact date with me, but the user based testing has been completed and ticked off.

Senator WATT: So it's been completed. You're not sure if it happened by mid-September?

Mr Madden: No. I can check that., if you like.

Senator WATT: Mr Paull, do you know?

Mr Paull: I don't have that detail with me.

Senator WATT: You said that updates to Medicare and state and territory data were needed in mid-September.

Mr Madden: We have had complete testing of the migration and integration of the Medicare and the state and territory data on three occasions so far. They've happened all the way through to September. Again, we continue to work on that integration process on the basis that data continues to be updated on a daily basis to date.

Senator WATT: That's ongoing?

Mr Madden: Yes. Even beyond implementation, we'll get a daily feed of updates to the Medicare register as new people are added or when people reach a particular age.

Senator WATT: The updates that were required in order for it to go live have been done, but there's ongoing updating?

Mr Madden: The updates to be able to bring that data together have been tested. When we migrate the state and territory data from mid-January, that will be the final instalment to bring the latest version of the state and territory data through. That will be ongoing through until we transition all the states and territories to the new system.

Senator WATT: Go-live was going to happen on 20 September. Has that happened?

Mr Madden: No.

Mr Paull: Go-live will now happen just prior to 1 December. I don't have the date in front of me, but it will be about three or four days prior to—

Senator WATT: So it will be in late November?

Mr Paull: Yes.

Senator WATT: Feel free to go back and check this, but, assuming you had previously said 20 September, that's a pretty big delay. Is there any risk with go-live occurring only a small number of days before it's supposed to be operational?

Mr Madden: I think there is a final checkpoint which locks in the final security assessment and the final system test reports—the whole bit. Those things will occur before the late November point. But I don't see a significant risk in that final go-live decision. I think go-live was a decision point as opposed to the system being live. The go-live decision point is towards the end of November, but I don't see that as being a big risk to the system going live on 1 December.

Senator WATT: I'm conscious that there have been a number of IT projects not only in your department but also across government in recent times where there have been some pretty significant IT failures, whether it be the census or robo-debts. There are delays here. You're not at all anxious that there's a pretty small window there before it's up and running?

Mr Madden: I've been part of lots and lots of large and small system implementations, and I can tell you: not any one of them goes exactly to plan.

Senator WATT: That would appear to be the case.

Mr Madden: So I think prudently we would, and we continue to, work on: what's the risk, and what do you do if that happens? In terms of our own program, we use—I'm not sure if you've heard the term before—the gateway review process, which is where a set of independent project assessors come in and have a look at what you're doing, look at the progress and look at what's really there versus what people are telling them. We had a recent review of the current plans three weeks ago now. They've come back and given a high level of confidence rating on the ability to succeed on the 1 December implementation.

Senator WATT: There were two further milestones: migration complete—you previously said that the first state or territory would migrate to the new system in mid-October. Has that happened?

Mr Madden: We've changed the implementation logistics and strategy. Previously we were looking to transition states and territories pre 1 December, starting from the middle of October and finishing by the last week of November. We're now going to the go-live of the register itself, supporting the renewal program, from 1 December, and migrating states and territories from mid-January. During that intervening period between 1 December and mid-January, or whenever each state and territory has completed, which is by the first week of March, those states and territories will continue to provide pre-1-December screening histories to path labs as required. So we've actually changed the order; we consciously did that in the transition plan.

Senator WATT: So there's been a conscious decision to change tack there.

Mr Madden: Yes.

Senator WATT: And then again, system operational on 1 December—but, as we've already discussed, there are some significant things yet to be completed after 1 December, some by mid-January and some by 1 March.

Mr Madden: The system things will be completed by mid-January. The things happening between mid-January and the first week of March are the migration of the state and territory data. So the system is complete. There is no system work beyond the middle of January.

Senator WATT: What exactly is the point of having a register on 1 December if it doesn't have the data that it needs until mid-January or March?

Mr Madden: The first piece of data that the register needs to be able to cater for is HPV and LBC tests. None of the current state and territory registers are capable of receiving HPV tests, so we do need a register to store, to inquire on and to retrieve the results of those HPV tests, and to be able to run reports for those who've got positives to make sure the first step of follow-up's taken. That will be there from 1 December, so the first function is to store the new tests. If we didn't have anywhere to store the tests, we wouldn't be able to start the new tests. That's the difference. The staging of the functionality is in two pieces. Going back to large systems-based implementations, big bangs are generally more risky than two small ones. So what we have is that we have the register to support the new reporting from 1 December, the rest of the functionality in the middle of January, and migration from that date through to the first week of March.

Senator WATT: Okay—I'm really sorry. It's been a big week.

ACTING CHAIR: It's just been a big 24 hours.

Senator SINGH: Can I just follow up: why does the migration take so long?

Mr Madden: From state and territories?

Senator SINGH: Yes.

Mr Madden: Each of those has got anywhere between 15 and 35 years of history. When we move the state and territory data, the last test result for a woman from a state and territory needs to be brought into the new system, from a pap smear regime on a two-yearly basis into a new clinical algorithm to detect and put the woman on the correct clinical pathway under the HPV screening program, which is a five-yearly program. So the moving of the data, and the testing to make sure we've put people in the right place, is a confidence tool that we use to make sure that we haven't created any errors at a clinical level with the data.

Senator SINGH: So if someone has had cervical cancer in the past, and that's currently in the state data, the register won't know until March?

Mr Madden: That's right. But remember that the specialist who has been dealing with the woman who has got a cervical cancer is the one who's treating the woman. The register doesn't treat the women. The register will send reminders about time for a retest, but it doesn't actually interact with women to tell them what to do unless it's an invitation or a follow-up to say, 'Has this happened?'

If there was somebody with a result pre-1 December that needs to be actioned, it will be actioned under its current regime through the states and territories that manage their own register until it's transferred to the national.

Senator WATT: I'm not a doctor, but I imagine if someone has had cervical cancer in the past, there's additional risk factors there. So you will have a register on 1 December that isn't aware of whether someone's had cervical cancer in the past, but by 1 March it will know if someone has had it in the past because it will then have access to state and territory data?

Mr Madden: The register will know. But again, the register is not the only one that knows somebody's got cervical cancer. The woman and the doctor—

Senator WATT: Sure, but the whole point of the register is to integrate all available data.

Mr Madden: Yes. Again, all of the actions on the data up until 1 December and the follow-ups from that point will stay with the state and territories until the data is migrated. All of those positives—high grades and all of those results—will continue to be actioned. The algorithm that is applied would be those who turned up that had a negative result in a pap test, in the new world they'll be put on the right calendar for when they should have their HPV test. Then from that point on they'll go into a regime. If they had, not a positive cancer, but did have a high-grade result, then it would determine whether they get followed up in 12 months or some other period. But at the point where that test was returned to their old register, they would have already been put on a regime for when they're going to go through the next screening or be sent to a specialist or be referred to another treating physician.

Senator DUNIAM: I'm trying to get my head around these dates. From what you said, Secretary, from 1 December a better test is available which would deliver better results and potentially save lives—is that right?

Ms Beauchamp: That's correct. That's our priority in terms of managing this project. The risk we referred to is ensuring this test was going to be available for women on 1 December, and then looking at transferring that historical data from that time after that in a very considered way that took into account state and territories' readiness as well. There are a number of stakeholders here, and I think there are comments being made about large projects and ICT projects, but our priority was to make sure this new test was available for women on 1 December.

Senator WATT: Sure, but whatever register you do have up and running on 1 December won't know whether someone has had cervical cancer in the past, and it won't know that until 1 March?

Mr Paul: The specialists and the pathologist clinicians who are making determinations will have access to that historical data through the state and territory registers. The national cancer screening program is a screening program, not a clinical program that deals with actual cancers. That's a healthcare provider function. Hence the 12-week period where we say that the follow-up needs to happen. It's only when we receive results in the register for unsatisfactory results where there needs to be an eight-week follow up. There's still an onus and a requirement for the healthcare providers and clinicians to undertake their primary care responsibilities. The register itself is a safety net for that. We have that eight-week follow-up period that the register will still be able to do in that 12 weeks. Similarly for historical results under the pap regime, the state and territories will remain responsible for that follow-up.

Senator WATT: I'm not sure if you remember this, Professor Murphy, but back when the delay was announced in February, you said effectively that the new test couldn't go ahead without a national register. The direct quote from you was:

Without a register function, there will be no national system in place to provide screening histories to laboratories to inform clinical decision-making and no 'safety net' supporting women with positive test results to get the follow up they need.

Doesn't what we have heard today mean that we have got another four-month delay to get to that point that you say is needed for the system to be in place?

Prof. Murphy: No. The screening histories will be available the whole way through, through the state registers. What I was saying back then referred to going live with the renewal with no prospect in that 12-week period where the safety net needs to kick in of having a check. The register is always a safety net. The primary responsibility is with the treating clinicians and the pathology labs. The register is there as a safety net and all of that data will be available to the pathologists when they look at the sample or until they order in the tests from the state registers in this transition period. The full consolidated safety net function will be available within that 12-week period. I have just spoken to the president of the College of Obstetricians and Gynaecologists, the president of the College of GPs, the AMA—they're all extremely excited about this new technology where evidence is showing it's much, much better than pap smear.

Senator WATT: When they get it.

Prof. Murphy: They're very comfortable with this transition period and they're quite comfortable that this is a fully safe implementation.

Senator WATT: It's good that they feel that way, but obviously my primary concern here is people in the community who might be at risk of getting cervical cancer and might be exposed to risk by delays. I remember very well being at that Senate inquiry last year, when we were coming under significant pressure to pass the legislation. What we were being told was that any delays in passing that legislation would cost lives. Here we have got again, not just a delay to 1 May this year, but now there are critical aspects of this system that won't be up and running until 1 March.

Prof. Murphy: I don't believe they are critical aspects. I think the primary functionality of getting the new information and somewhere to store the new HPV and LBC tests on 1 December will be there. That will enable the renewal to go ahead. The transitional elements are perfectly safe within the window required before a safety net needs to kick in. We're very confident that this new and exciting test will be going live on 1 December and it will be safely implemented.

CHAIR: We're going back to health workforce, 2.3. We will be going back to 2.4.

Senator KAKOSCHKE-MOORE: My health workforce questions relate to remote area nurses. I met with Minister Hunt on 21 June this year. During that meeting he undertook to respond to CRANaplus remote health workforce study by 1 August this year. I then received a letter from him dated 10 August, but that made no mention of the CRANaplus report. My letter in response to him asking where the response was to the CRANaplus report hasn't been responded to. Can you tell me whether the department has been instructed to respond to the report?

Mr Hallinan: The CRANaplus report is quite a detailed report targeted at employers and employment arrangements for remote nurses and the sorts of circumstances or things they might put in place in employing nurses. The government doesn't have a role in employing remote workers. We finance a range of organisations that do, and outside of that state and territory health departments also employ workers in remote locations. The actions that we have taken in response to that report include we've distributed it to the organisations that we finance that do employ remote workers. We have distributed it through state and territory departments of health, and we have further financed CRANaplus to undertake an education program that can be rolled out to remote workers and employers to support them in implementing those recommendations.

Senator KAKOSCHKE-MOORE: I'm aware of all of that. I suppose what I want to know is—and just by your answer it sounds like the answer is no—but the government won't be providing a formal response to the report it asked for?

Mr Hallinan: The report's intended to assist employing organisations in their management around appropriate safety of remote workers. It's not a report that the department or the government has got the ability to respond to in many respects other than to disseminate it and try to promote its uptake.

Senator KAKOSCHKE-MOORE: I think I put this as a suggestion to the department at the last estimates, but the Commonwealth does play a very substantial role in the funding of many of these community health organisations, so I suggested that perhaps some of the safety and security recommendations in the CRANaplus report could be used as levers or conditions

of some of this Commonwealth funding being made available to the organisations. Has any consideration been given to that suggestion?

Dr Studdert: It's true that we fund a lot of community controlled Aboriginal health organisations and we certainly work with them on a range of implementation issues, but they are community controlled organisations so ultimately decisions around management of employees are theirs to make.

Senator KAKOSCHKE-MOORE: The minister has also advised that the Department of Health would nominate that the remote area health worker safety issue should be placed on the AHMAC agenda. Has this occurred?

Mr Hallinan: It has. It's been considered through the health workforce or the former Health Workforce Principal Committee and will be subject of consideration at the next COAG Health Council, I think, in November.

Senator KAKOSCHKE-MOORE: You may be aware that South Australia is about to pass a bill that says it will give effect to Gayle's Law, which will require two responders to a callout in a remote area. Has the department had any discussions with the South Australian government about their legislative move?

Mr Hallinan: We've had discussions at an officials level around responses that states and territories are employing in response to remote worker safety issues. We're aware of what South Australia is doing. It's an amendment to the national law for regulation of health practitioners, but for South Australia only. My understanding is that it's a second attendee to come along with the remote worker in after-hours callouts and for that individual to be met prior to—

Senator KAKOSCHKE-MOORE: Attending the scene.

Mr Hallinan: Prior to the attendance, yes.

Senator KAKOSCHKE-MOORE: So you're aware that this legislation will apply to health services that receive federal government funding?

Mr Hallinan: Yes, we are.

Senator KAKOSCHKE-MOORE: Do you think there could be more engagement with South Australia about this new legislation so you can understand its impact on these federally funded health services to ensure the law can be met?

Mr Hallinan: We are engaging with all state and territories through the AHMAC framework and there are opportunities for us to look at that in some detail through the AHMAC structures. Our advice to date has been that the implications of the law are unlikely to be substantial for Commonwealth funded entities. Many already employ dual callout procedures, and others have—we haven't had a strong feedback to suggest that there would be a substantial effect on any of the Commonwealth funded providers.

Senator KAKOSCHKE-MOORE: Going back to when COAG will be considering this issue in November, you quite rightly pointed out that the bill that's being introduced in South Australia amends the national law but only for nurses operating within the South Australian borders. Will there be any discussion around amending the national law so that Gayle's Law would apply across the country and not just to those states that have made the move themselves to protect the safety of nurses?

Dr Studdert: We wouldn't want to anticipate the discussion of ministers at the meeting next week, but that could well be something that would be put on the table. That would be a decision for ministers, and we wouldn't want to anticipate that.

Senator KAKOSCHKE-MOORE: Can the department suggest that this issue be discussed at COAG, in terms of amending the national law, or does that have to come from the federal health minister?

Dr Studdert: We'll certainly make the minister aware of the range of options and proposals that are around, and that would be for him and his colleagues to consider in that meeting.

Ms Beauchamp: Probably the most important thing is the fact that it's on the COAG agenda. The senior officials group are supporting that group. Given that the state and territories are the responsible employing jurisdictions, without unanimous support across all states and territories in a sense the Commonwealth working in a unilateral way or on its own would not be effective. The real onus is on the state and territory jurisdictions.

Senator KAKOSCHKE-MOORE: Do you think, though, that the Commonwealth does have a role to play in the sense that you do provide such a substantial amount of funding for a lot of these organisations that operate in the areas where the nurses are at risk if they attend callouts on their own?

Ms Beauchamp: Certainly we're one player amongst a number of jurisdictions, and I guess that's why it's on the COAG agenda.

Senator KAKOSCHKE-MOORE: I think next estimates I'll ask for an update on how that meeting went. That was all my questions for health workforce.

CHAIR: This may have been covered while I was at another committee briefly, so, if it has been, just tell me. How is the Rural Health Commissioner going to work with what already exists in the rural health space: the rural training pipeline? Does, effectively, the Rural Health Commissioner take on responsibility for that existing pipeline? Is that how it works?

Dr Studdert: That's not intended to be taken on. It's a supplement to the mechanisms and resources we already have in that place. The commissioner has been asked in particular in the first instance to look at the issue of the Rural Generalist Pathway, which is a much discussed proposal to expand the skills and expertise of—

CHAIR: What I'm trying to get to is, is the Rural Generalist Pathway just another way of describing the pipeline?

Mr Hallinan: Not quite. There are a range of policies that the government's had in place—some of them longstanding—in relation to rural medical workforce, allied health workforce and nursing workforce training in rural Australia. The integrated rural training pipeline was an announcement in the 2015-16 MYEFO. It expanded on a range of existing activities and created some new ones. There were a few new university departments of rural health announced, which are sites where we'll finance a university to establish both clinical training research and network support to a region. They'll provide training to undergraduate students, they'll do research and they'll provide network support to a region's professions. There was an expansion of undergraduate allied health and nursing training through the existing university departments of rural health. There was also an expansion of our specialist

training program, which is a program which tries to target specialist medicine training and push it west—if you will—or push it into rural areas.

CHAIR: Push it west, I agree.

Mr Hallinan: That expanded by 100 places. We've rolled out the first 50, and we're in the midst of rolling out the second 50 into next year. On top of that there was the establishment of regional training hubs. There has been some pretty heavy infrastructure built in rural Australia through those programs that I identified: the clinical schools and the university departments of rural health. The regional training hubs will build on that infrastructure and try to support more-networked arrangements of training for vocational training, in medicine in particular, which is to try support the specialist training programs another things and try to get more doctors trained in situ in rural Australia.

The National Rural Generalist Pathway, as it's described, is a policy idea that has largely fallen out of Queensland. Queensland set up a rural generalist pathway 10 to 15 years ago. It's a program which takes general practitioners and gives them advanced skills, so you'll train a GP with advanced skills in surgery, obstetrics, anaesthesia, perhaps mental health or Indigenous health. They can then be employed to both provide general practice primary-care services in a small regional or rural community, but also provide services in the hospital environment. They're the workforce that can keep open obstetric units in the country and keep open and running the smaller hospitals that aren't of a large, tertiary nature. The job that Professor Worley's been given, with the development of national rural generalist pathways, is to try to build on the existing infrastructures that we have out there and try to establish pathways for that rural generalist workforce—the easiest way to describe it is general practitioners with advanced skills. They can be employed then as visiting medical officers in rural hospitals. Due to the differing nature of each state and territory's employment arrangements and hospital arrangements through rural areas, we recognise that that pathway may be pathways. The commissioner's role is to try to assist in navigating how to build that workforce, which is really a critical workforce to keep rural hospitals open.

[15:20]

CHAIR: Thank you very much. We're going back to 2.4.

Senator SIEWERT: I have a fairly simple question: where is the national FASD strategy up to? It's a simple question with, I suspect, a complex answer.

Mr Laffan: The FASD strategy is currently in development. It's just finished a consultation phase where there were a number of consultations around the country. They were face to face, and the department received some written submissions. We anticipate that the FASD strategy will be available early next year.

Senator SIEWERT: Could you take on notice to outline the consultation process and who was consulted.

Mr Laffan: I can tell you about it now, if you'd like.

Senator SIEWERT: Okay. I am conscious of time so, if it's fairly quick, that would be appreciated.

Mr Laffan: There were workshops held between 1 August and 4 September. They had individuals and organisations working with people affected by FASD, public health

organisations, representatives of state and territory health departments and local health services present. Those workshops were held in Sydney, Melbourne, Brisbane, Perth, Broome, Hobart, Adelaide, Canberra, Cairns, Alice Springs and Darwin. One hundred and forty-eight participants attended those face-to-face workshops, and 32 submissions were received via the online submission process.

Senator SIEWERT: Sorry, how many people attended?

Mr Laffan: There were 148 participants.

Senator SIEWERT: In that list, did you say Broome?

Mr Laffan: Yes, I did.

Senator SIEWERT: I thought you did, thank you. So what's the process from here? You draft it up. Will a process be gone through for further public review of the strategy?

Mr Laffan: No, I don't think there'll be a further public review, but the department will receive the final consultation report shortly and then have a look at the draft strategy and what changes might need to be made from that consultation, with a view to its release early next year.

Senator SIEWERT: There won't be another step in between what's come out of the consultation process, the next version and it going for final approval by the minister?

Mr Laffan: No, the consultation process is complete.

Senator SIEWERT: Okay. Were there major things that came out of that consultation process?

Mr Laffan: I'd have to take some of the specifics on notice.

Senator SIEWERT: Could you take that on notice: what were the major issues that came up in that process?

Mr Laffan: Certainly.

Senator SIEWERT: Thank you.

Senator SINGH: The new National Bowel Cancer Screening Program was due to go live on 20 March—I think it was—this year but has been pushed back even later. In last estimates, Mr Bowles told us that we were looking at a 12-ish-month delay to the first part of the next calendar year, so 2018. Have you now got a more specific date than that that you can provide us? Have you have got milestones to meet that date, if you have a date?

Mr Madden: We had done a provisional schedule. Our focus has been completely on supporting the Renewal of the National Cervical Screening Program. We have done a provisional plan for the bowel program, which would be before the middle of next year, so before the middle of 2018. We will continue on the transition planning for bowel in the next month, during November—sorry, I'm just trying to figure which month we're in!—to confirm whereabouts during 2018 that will be delivered.

Senator SINGH: So you still don't have a date, and you're now saying up to the middle of next year, not the first few months?

Mr Madden: During the first half of 2018 is where we're planning. We have a provisional date where we have planned that to, but we haven't publicised that because we need to check

that against where we have been around the cervical delivery. But, as I said, we've got to do the detailed planning between ourselves, Telstra Health and DHS during November.

Senator SINGH: Do you have any time lines to meet that?

Mr Madden: To deliver the bowel schedule?

Senator SINGH: Yes—so that it won't blow out beyond mid-next year.

Mr Madden: We have a draft schedule which we prepared some time ago. During November, we're going to turn that into a detailed schedule which will land exactly where that is expected to be in the first half of 2018—together with the project plan that gets us there. Again, the detail of that needs to be worked with Human Services because they're the current provider of the bowel screening register today.

Senator KAKOSCHKE-MOORE: My questions cover two areas—the bowel cancer screening program and the local drug action teams. How many test kits did the bowel cancer screening program send out in the last 12 months? If that's not readily available, you can take it on notice.

Mr Smith: I will have to take that on notice.

Senator KAKOSCHKE-MOORE: According to the most recent monitoring report, the participation rate is about 39 per cent your target. Your target this year is 48 per cent. How is it tracking this year?

Ms Creelman: I can't give you an interim figure for how it's tracking. But what I can say is that we have a number of measures in place and we are seeing an increase in participation. One of the things driving that, as you may be aware, is that we're moving progressively to two-yearly screening. By 2020, everyone aged between 50 and 74 will be invited every two years, which is in line with the National Health and Medical Research Council recommendations.

Senator KAKOSCHKE-MOORE: By the end of the year you'll be able to advise us what the participation rate was?

Ms Creelman: Yes. What we do know is that the re-participation rate of people who have previously been invited is much higher than the initial participation rate. As people get invited more we are already seeing it increasing. We're also doing a lot of work in terms of publicising the program to general practitioners and so on. So we are seeing an increase.

Senator KAKOSCHKE-MOORE: Chair, I want to get a sense of my time allocation.

CHAIR: You have two minutes until the break.

Senator KAKOSCHKE-MOORE: Will I be able continue after the break?

CHAIR: You'll be able to continue.

Senator KAKOSCHKE-MOORE: Thank you. I'll finish up with bowel cancer screening and then move on to drugs. I noticed the participation rate decreased from 44 per cent in 2008 to 26 per cent in 2012-13 and then increased again to 39 per cent in 2014-15—and I note that South Australia has the highest participation rate. Why does that figure bounce around and do you believe it corresponds with awareness campaigns?

Ms Creelman: A number of factors influence participation. One factor is that participation is higher in older groups than in younger groups, so some of the bouncing around reflects

different age groups being introduced to the program. I can't say for sure that that was the reason in this case, but we are certainly conscious that older people do participate more highly. In the past few years we have had publicity campaigns that have talked about the program, and we do think that has an effect on increasing participation.

CHAIR: We will suspend there and take a short break. We will be back in 15 minutes. Senator Kakoschke-Moore, you will have the call when we return.

Proceedings suspended from 15:30 to 15:45

CHAIR: We shall resume, and Senator Kakoschke-Moore has the call.

Senator KAKOSCHKE-MOORE: Thank you very much, Chair. I'm moving on to the local drug action teams now.

Dr Studdert: Just before we move on, you asked about the number of tests—

Senator KAKOSCHKE-MOORE: Yes.

Dr Studdert: and we do have that number now to give to you.

Mr Smith: In the order of 1.9 million test kits were sent out.

Senator KAKOSCHKE-MOORE: Sent out this year?

Mr Smith: Yes, that's a 2016-17 number.

Senator KAKOSCHKE-MOORE: Fantastic, thank you. I'll just move on to **LDAT**, the local drug action teams. I understand that 80 of the 220 teams have been announced and six of them are in South Australia. What I'd like to know, now that round 2 has been announced, is: are you able to tell me the total number of applications that were made in each state and territory, including the applications that were unsuccessful? If that needs to go on notice, that's fine.

Mr Laffan: In relation to the completed applications, in round 1 there were 225 applications that were commenced but 77 complete applications were lodged with the Alcohol and Drug Foundation. In round 2, there were 114 applications that were commenced and 70 complete applications lodged.

Senator KAKOSCHKE-MOORE: Were all of those complete applications approved?

Mr Laffan: No. For example, in round 2, 70 complete applications were lodged and 40 were announced as LDATs.

Senator KAKOSCHKE-MOORE: Are you able to give us a breakdown of the areas where those unsuccessful applications were made? I'm try to get a sense of if they were in metropolitan areas or rural areas.

Mr Laffan: For unsuccessful applications we'd need to take that on notice.

Senator KAKOSCHKE-MOORE: That's fine, thank you. I'd also like to know what some of the reasons are for unsuccessful applications—not those that were commenced and they just never completed the application but the completed applications that were knocked back. What are some of the reasons why and also what sort of feedback is provided to those organisations that made an unsuccessful application?

Mr Laffan: I don't have a specific list of reasons in front of me, although of course you'll appreciate that, with a competitive round that's been undertaken, in the assessment by the

independent expert panel they've made the recommendation to the Alcohol and Drug Foundation that these were the best 40 to proceed.

Senator KAKOSCHKE-MOORE: Was that a cap—that only 40 could be approved in round 2?

Mr Laffan: No, there's no cap. They're just looking at the quality of the applications.

Senator KAKOSCHKE-MOORE: That's good to know. Also, I understand that a total of \$40,000 is available, with an initial \$10,000 given—

Mr Laffan: That's correct.

Senator KAKOSCHKE-MOORE: and \$30,000 can be granted following that.

Mr Laffan: Up to \$40,000 in a year.

Senator KAKOSCHKE-MOORE: Can those organisations apply for an extra \$30,000 every year or do you get just the \$40,000?

Mr Laffan: These LDATS in round 2 get \$10,000 to complete their community action plan as part of being announced as the lead organisation. They have the ability to get up to \$40,000. So that extra \$30,000 is part of the next grants round. Then in the following annual cycle they have the ability to put forward a proposal for an additional \$40,000 each year until the completion of the program.

Senator KAKOSCHKE-MOORE: So the initial process is if you're successful you get \$10,000 to apply to put together a community action plan. If you're satisfied with the community action plan, they'll get \$30,000 to assist in implementing it. Am I understanding that?

Mr Laffan: No, not necessarily. There's a separate grants round with the Alcohol and Drug foundation where there's an assessment that takes place—again, with an expert panel—as to the merits of the proposals that are being put forward. They might receive an extra \$5,000 if that's what's needed to implement their plan or up to \$30,000. There will be a balance as part of that assessment process.

Senator KAKOSCHKE-MOORE: Okay. Can you tell me what analysis you're doing on the LDATs that have been established and the work that they're doing? How do you ensure that they're achieving what they said they were going to achieve with the money?

Mr Laffan: There's an annual reporting process which is required for those LDATs. The LDATs that were successful in round 1 need to provide an annual report to the Alcohol and Drug Foundation by the end of this month.

Senator KAKOSCHKE-MOORE: Is that report made public—are we able to see it?

Mr Laffan: I'm not sure; I don't think it is. But there'll be monitoring to ensure that they are achieving the outcomes they set out to achieve and are conducting activities they said they were going to do with that grant money.

Senator KAKOSCHKE-MOORE: You haven't had any feedback yet on the first round of funding. These are the first reports that will be tabled.

Mr Laffan: Yes. We have some anecdotal information but the reports themselves will come through to the Alcohol and Drug Foundation at the end of this month.

Senator KAKOSCHKE-MOORE: Will you take on notice whether or not they'll be made public?

Mr Laffan: I can take that on notice, yes.

Senator XENOPHON: Back on 30 August 2016 I asked what I thought was quite an innocent question. That question related to how much the Australian government spent in the investor-state dispute arbitration between a tobacco company and the Australian government over plain packaging, over that dispute that was held in a Hong Kong jurisdiction. Are you familiar with that, Ms Beauchamp?

Ms Beauchamp: I am familiar with that, yes.

Senator XENOPHON: I was told that it was designated 'not for publication'. In the context of FOI that is not a lawful reason for not providing the information. Then I was told it was confidential to cabinet, which was subsequently dropped. I have gone through an extensive FOI process. There was an exchange in estimates, on 19 October 2016, that it could prejudice the cost case, and there was a cabinet in confidence. I agreed to revisit it. The cost case has now been completed. I initiated another FOI on 23 October 2016. The Information Commissioner, back on 2 February 2017—there were extensive submissions. There were various claims made about cabinet in confidence. All those claims have been abandoned. You have now thrown up a new claim as to why it can't be provided to me, the cost to taxpayers of that dispute, which, by the way, we won—that's right, isn't it, that we won the case?

Ms Beauchamp: That's correct.

Senator XENOPHON: And we actually got costs from the tobacco company. The reasons given are that it would be prejudicial—it would 'cause damage to the international relations with the Commonwealth' if we knew what the costs were—and it goes on to say that, somehow, it might deter other countries from being involved in tobacco control if they knew how much the costs were. Is that seriously the position of the Commonwealth? I think I have fairly summarised what the—

Ms Beauchamp: I think what you've been presented with is a fair summary, yes.

Senator XENOPHON: Is it defensible that Australian taxpayers can't find out what this dispute cost is? I thought was a pretty outrageous action by the tobacco companies, so I'm very pleased that Australia won it and got costs from big tobacco. Is the Commonwealth of Australia seriously saying they will not tell us what the costs were, involved in that case, because it's 'expected to cause damage to the international relations of the Commonwealth'? How so?

Ms Beauchamp: We're working through those issues, within government, at the moment. I must say, having been in a number of portfolios, it is very unusual for the department and the government to provide legal information, particularly litigation costs as well.

Senator XENOPHON: Why so?

Ms Beauchamp: We've got to work this through a number of avenues, and I think we're in the process of doing that with the Information Commissioner and others.

Senator XENOPHON: I feel I've been played on this. You come up with all these reasons that you abandoned, so then the FOI starts all over again. It sounds very much like a stalling tactic on the part of the Commonwealth. What is wrong with Australian taxpayers knowing

how much was involved in these costs? How can you seriously say that this will somehow deter other countries around the world from pursuing tobacco control measures because of the costs involved in this case—which, by the way, we've recovered, presumably, to a significant degree from big tobacco, because we won the case. I would have thought it would have the opposite effect, that it would be a warning to big tobacco not to take these sorts of spurious actions.

Dr Studdert: I can certainly go through what the harms are, as we have assessed them, in terms of the international relations.

Senator XENOPHON: International relations or the Commonwealth?

Dr Studdert: Australia has obligations under the World Health Organization Framework Convention on Tobacco Control. Under article 22 it requires cooperation with other parties or through competent international bodies to strengthen parties' capacity to fulfil obligations under the treaty. Australia takes its treaty obligations seriously and, as such, has taken a leadership role in international tobacco control and was the first jurisdiction to implement strongly legislated measures for tobacco plain packaging. Australia's leadership in tobacco control policy has facilitated strong international relationships with foreign governments and has strengthened Australia's position to influence tobacco control and global health matters more generally.

Senator XENOPHON: Ms Studdert, I'm sorry: I'm really short of time. Chair, you've told me I've only got a few minutes. This is directly to what you have answered so far—

Dr Studdert: I was just getting to my last paragraph, if I could. The information requested could be used by tobacco companies as a tool to discourage international engagement on these issues. A reduction in the opportunity to engage internationally could damage Australia's relations with other countries in their development and their ongoing implementation of tobacco control and health related measures.

Senator XENOPHON: What part of the treaty says that we can't disclose the costs involved in tobacco litigation that Australia actually won against big tobacco?

Dr Studdert: Well, that is, we are obliged to—

Senator XENOPHON: Is it in the treaty? Is it contrary—

Dr Studdert: work within the spirit and intent of that treaty, which is to support other countries and work cooperatively with international—

Senator XENOPHON: So you're saying it's against the spirit and intent of the treaty for us to disclose this information as to the funds, as to how much it costs to be involved in the litigation.

Dr Studdert: That is our assessment.

Senator XENOPHON: Which part of the treaty relates to the spirit or intent? Can you point to me which clause of the treaty?

Dr Studdert: I pointed to article 22, which requires cooperation with other parties or, through competent international bodies, to strengthen parties' capacity to fulfil obligations under the treaty.

CHAIR: Excuse me, Senator Xenophon: I'll just interrupt there for a moment. Someone's come into the room filming.

Senator XENOPHON: That's my fault, I'm sorry. It's from the ABC. I apologise.

CHAIR: Does anyone on the committee object? There is a lot of silence, but no objections.

Senator WATT: I would love Senator Xenophon to be on TV!

CHAIR: Please continue, Senator Xenophon.

Senator XENOPHON: Could you point to me—you say that other than those general provisions under article 22 it would go against the spirit and intent of the treaty for these costs to be disclosed.

Dr Studdert: That is our position.

Senator XENOPHON: Can the Commonwealth assure me that there will not be, after months and months of FOIs toing and froing, an abandonment of those claims for some fresh claims, so it takes another couple of years?

Dr Studdert: These are complex matters on which we need to consult with all our colleagues across government. As has been the case since the start of this process, we continue to do that. I don't think we could give you an assurance on behalf of all aspects of government.

Senator XENOPHON: But why is it you put up all these claims and then you abandon them after basically—I feel that I've been treated like a mug by the department, because you put up all these claims that you just simply abandon and then start afresh with fresh grounds.

Dr Studdert: We haven't abandoned them; the situation has evolved.

Senator XENOPHON: Well, you have abandoned them.

Dr Studdert: No, it's continued to evolve, and the circumstances and situation have changed. With the cessation of the litigation and further developments on international relations, we have identified this as a current reason.

Senator XENOPHON: Finally—the chair's been very patient with me—can you please point to any documents, any evidence, any basis on which you say that this could cause damage to the international relations of the Commonwealth? Have you had any representations from any other countries? If you tell the world how much you spent on the costs that you won, in a case that you won and recovered costs, how will that damage our international relations?

Mr Wright: As part of this—

Senator XENOPHON: You're from the FOI branch, are you?

Mr Wright: I am.

Senator XENOPHON: You're the one who's been torturing me for the last few months on this!

Mr Wright: No, I wouldn't put it like that. We've consulted very widely as part of this particular FOI process. We do believe that international relations is the most appropriate exemption at this point in time. We have sought submissions from AGD and DFAT as part of our submission to the information commissioner—I understand from the Office of the Australian Information Commissioner that you have been provided with a copy of our

reasoning for that particular submission—and the matter is now with the information commissioner for his consideration.

Senator XENOPHON: Mr Wright, I won't be seeing you again at estimates, but I think I might be seeing you at the AAT, so thank you.

Senator Nash: As we know, Senator Xenophon is leaving this place. In the spirit of Senate collegiality, can I sincerely wish you all the best for your future path.

Senator XENOPHON: Thanks. I'd still like the FOI response, though!

Senator SIEWERT: It means no more questions today, now that we've said that!

[16:00]

CHAIR: We're going to try to move through 2.5 and 2.6 relatively quickly. Senator Siewert, on 2.5, I believe?

Senator SIEWERT: Yes, please. I think it's a question that you'll need to take on notice, so it should be quick. In question SQ17-000598, you took on notice some of the residential rehab services in Western Australia, in particular, and you answered that there's one in Northam and in South Hedland. Could you now please take on notice what treatment support centres are available in the Mandurah region, now that the Mandurah region has been selected as a drug-testing site?

Dr Studdert: So you would like to know which services the Commonwealth is funding in that region or overall?

Senator SIEWERT: I would like a more comprehensive list of overall, please.

Dr Studdert: We have that.

Senator SIEWERT: You do have it?

Dr Studdert: It's probably quite long and detailed—

Senator SIEWERT: That's what I said. If you have it and could table it rather than me having to wait ages for it—if, between now and tonight, you could table it—

Dr Studdert: Okay.

Senator SIEWERT: could you include any treatment services that you're aware of. In particular, when I look at the answer to that question, it looks like there is, to my knowledge, at this stage no residential treatment centre in Mandurah.

Mr Laffan: We won't be able to provide a list of everything we're aware of, just those that receive Commonwealth funding through different Commonwealth services.

Senator SIEWERT: Okay. Has there been any work done on what state services are available in that region?

Dr Studdert: We'll take that on notice.

Senator SIEWERT: Could you take that on notice and provide what you can tonight.

Dr Studdert: All right.

Senator SIEWERT: If you can take that on notice, that would be appreciated. Could you also take this on notice, if you can't answer it now. In answer to that question, you articulated Northam and South Hedland as residential rehabilitation services, which are quite some

distance and a very large distance away from Mandurah. Which residential treatment services would you be using or would you envisage would be used for the drug-testing trial?

Dr Studdert: Senator, just to be clear: there's no prescription around what the treatment services will be.

Senator SIEWERT: I know that.

Dr Studdert: That would be up to the clinicians and the clients.

Senator SIEWERT: Yes, but residential treatment services are required for many people with addiction, so, if you could take on notice which services you would intend that people would use, that would be very much appreciated.

Dr Studdert: Okay.

Senator SIEWERT: Okay, thank you.

CHAIR: Does anyone have questions in 2.6, primary care practice incentives?

Senator GRIFF: I have 2.5.

CHAIR: You have 2.5? Sorry.

Senator GRIFF: In answers to my questions during the May estimates regarding the primary health networks, most of the measures provided were actually process measures, not outcome measures. And, if we look at even the headline indicators—the top four headline indicators you have of potential preventable hospitalisations, childhood immunisation rates, cancer-screening rates and mental health treatment—wouldn't it be more effective to base it on outcomes rather than just processes?

Ms Cole: The four that you mentioned were chosen at the beginning of the program to apply to every single PHN in every single circumstance, and they related to two things. One was the six priorities which were set for PHNs, and the second was what was easily measurable without having to create a new database. That was essentially why those four were chosen. Subsequent to—

Senator GRIFF: Easily measurable for you without having to create another database is more important than health outcomes?

Ms Cole: No, it was more around the additional costs associated with creating a new database, which is actually surprisingly expensive.

Senator GRIFF: But shouldn't it be about outcomes like absolute cardiovascular disease risk or type 2 diabetes or obesity rates or something that's actually worthwhile for the community?

Ms Cole: Many of those things are in fact actually measured and are now being reported on by a PHN level as well. So, over the time of the original setting up of performance indicators for the PHN program, a lot of the currently available data or currently collected data is now being cut by PHN region, which allows the kind of data comparison over a time period that we are describing to see whether they're effective in linking up and preventing hospitalisations and so on and so forth.

Senator GRIFF: Are the PHNs responsible for collecting and providing this data, or is it automatically generated by Medicare?

Ms Cole: Those particular four are generated by external sources, but the PHNs themselves have a number of reporting requirements around not only outputs but outcomes to some degree as well, and we're just standardising some of those as time goes on and we get a bit more refined in our reporting methodology with the PHNs.

Senator GRIFF: Could you provide on notice the outcome measures that you're looking to.

Ms Cole: Yes, we can do that, for example in the mental health area.

Senator GRIFF: Okay, great. Thank you.

[16:06]

CHAIR: That was the end for 2.5. So 2.6, anybody? No? Let's move to 2.7, hospital services.

Senator SINGH: I want to talk about the so-called national funding cap, which is a cap of 6.5 per cent growth a year in Commonwealth spending on public hospitals. I understand that the Independent Hospital Pricing Authority models hospital spending in each state at the start of each year. Based on that modelling, how many states do you expect will reach their 6.5 per cent soft caps this year?

Mr Cormack: It's probably a bit early to make that assessment. We've still got to reconcile 2015-16 and 2016-17 activity baselines, but our provisional view is that they will operate within the 6.5 per cent cap.

Senator SINGH: But you model it at the start of the year, don't you?

Mr Cormack: Sorry?

Senator SINGH: You're saying it's too early, but you model it at the start of the year. Now it's October.

Mr Cormack: Essentially, the states and territories provide activity estimates. That's a forward-looking view as to what they think they'll be achieving, but we also need to reconcile the baseline because the activity projections can only be interpreted as exceeding or not exceeding the 6.5 per cent cap once the baseline is established. And we have a number of baseline issues to sort out to do with the 2015-16 and 2016-17 activity reconciliations.

Senator SINGH: So will each and every state operate within the cap, or is it nationally?

Mr Cormack: Our view is that, nationally, we'll operate within the cap, but that's a provisional view at this point in time because we need to reconcile the baseline activity to be able to bring that to account, and then we'll be in a better position to determine whether that 6.5 per cent cap is likely to be breached or not. But, as I said, our provisional view at this early stage in the first year of a three-year agreement is that we don't believe that that 6.5 per cent cap will be breached.

Senator SINGH: What do you mean by your 'provisional view'?

Mr Cormack: Essentially, the numbers that appear in the forward estimates in the budget papers are the product of historical growth trends at the state and territory government level. The baseline activity plus the activity projections are provided by the states and territories through the National Health Funding Body. So we draw all those together, and in the budget papers we have identified a forward growth pattern that will be underneath the 6.5 per cent

cap. Now, estimates change, but our provisional view is that, at a national level, the 6.5 per cent cap will not be breached.

Senator SINGH: So, are you saying that we won't hit the national 6.5 per cent cap?

Mr Cormack: Correct. We don't believe that we will.

Senator SINGH: But some states might.

Mr Cormack: Some states. The variations in activities across the states are quite significant.

Senator SINGH: Okay. What's your provisional view on each state and territory?

Mr Cormack: We don't have a provisional view on each state and territory, because the way that the soft cap arrangement works is that it's a dynamic model, and I'll ask one of my more technically orientated colleagues to talk you through that. Our accounts are brought together at a national level, and what's in the budget papers are what we believe to be the forward growth trends in activity and their translation into cost to the Commonwealth. As I said before, on the basis of the information that we have and the modelling that we did in the context of the budget, we don't believe that the 6.5 per cent cap at a national level will be breached.

Senator SINGH: Will be breached or reached?

Mr Cormack: Well, either.

Senator SINGH: Right. Sorry, Dr Hartland, did you have a breakdown?

Dr Hartland: Thank you, I'll get Mr White to respond.

Mr White: At the moment our projected expenditure for 2016-17 is \$18,469.8 billion, our projected expenditure for 2017-18 is \$19,562.6 billion and our projected growth is \$1,102.8 billion, which is a growth of six per cent. That would indicate that we're not expecting the national cap of 6½ per cent to be breached based on the estimates of activity provided by each state and territory.

Senator SINGH: How can you get a national view without modelling each state? I think the COAG agreement says that the IHPA will model each state, and you have very clear national views.

Mr Cormack: We bring together the historical growth trends. The best predictor of growth for the future is long-term,—or one of the best predictors—historical annual growth patterns in hospital utilisation. We have that data available, which is provided to us independently by the Australian Institute of Health and Welfare, and it is published every year. It gives us a very good baseline trend. On top of that we're able to look at more recent activity variations and the projections that are provided by the states, and on that basis we have reached the conclusion that I have described for you.

Senator SINGH: Okay, so there's no state-by-state breakdown.

Mr Cormack: There is a state-by-state breakdown of the funding flowings and the forward activity in the budget papers, but we don't focus on a state-by-state analysis as the way we budget; we look at the impact to the Commonwealth as a whole which is on drawing it all together at a national level.

Senator SINGH: I think you talked about a national growth figure, Mr White, of—

Mr White: It was \$1.1 billion at six per cent. I have the budget numbers in front of me. There are two jurisdictions showing a projected growth rate greater than 6.5 per cent. That is the ACT at 9.9 per cent and the Northern Territory at 11.5 per cent.

Senator SINGH: So that's the percentage of growth you're predicting in each state?

Mr White: For those two particular states. They're the only two over 6½ at this stage based on their estimates. Because there's funding available within a national cap of 6½ per cent, there's money available to fund those two jurisdictions in their entirety.

CHAIR: I will just interrupt momentarily. Senator Singh has the call so could senators who are having conversations perhaps pop outside.

Senator SINGH: I understand the minister has issued a directive to the Independent Hospital Pricing Authority, the IHPA, to review some funding methodologies used in previous years. Understandably the states are agitated at the prospect of a retrospective change. Six of them issued a joint press release in August and, I understand, the New South Wales and Victorian health ministers have also written a bipartisan letter to Minister Hunt. The states say that the directive could cost them hundreds of millions of dollars for services already delivered. Are they correct in that, Mr Cormack?

Mr Cormack: Senator, what the minister asked the IHPA to do was to review a number of counting issues, activity descriptions and the pricing that goes with those, and the IHPA have done that, and in fact, the IHPA are here today.

Senator SINGH: Are you saying you have modelled the impact?

Mr Cormack: No, we haven't. In looking at the 2015-16 reconciliations we identified some highly unusual patterns of activity increase. If I could just highlight that for you, Senator. In some areas of non-admitted activity, that's outpatient related activity, we saw activity levels increase by 4.5 per cent, which is not an unusual level of increase, but due to the change in counting that resulted in a 26.3 per cent increase in payments from the Commonwealth to the states. Now, it is incumbent upon the Commonwealth to not simply accept at face value a growth in outlays of 26 per cent related to raw activity increases of 4.5 per cent and not ask for explanations as to what is underpinning that. So the Treasurer asked the minister to investigate these activity variations, and that has been undertaken by asking the National Health Funding Body to review the activity levels and, on the basis of that, we were able to determine those unusual variations. Consistent with the National Health Reform Agreement arrangements, the minister consulted with state and territory governments on a draft direction, issued the direction to the IHPA and the IHPA has made a determination, as it's entitled to do, and that's independent of any further input from the Commonwealth. So that's where we're at.

I'd also say that it's not unusual, when you go back over the course of this agreement, when you do reconciliation of previous years' activity, for there to be, if you like, underpayments and overpayments because states will either over-project or under-project activity. When it's reconciled, payments go both ways, sometimes they'll go back to the Commonwealth if they are over-projections; sometimes they'll go back to the states if they're under-projections. This is simply a process of reconciling the 2015-16 financial year, predominantly, to settle that year and then to re-establish the baseline for subsequent years. This process has been worked

through, and it's been worked through according to the arrangements between the Commonwealth and the states, and it should be resolved in the coming weeks.

Senator SINGH: Isn't this direction a bit harsh, you know, to try to reclaim funding for services that have already been delivered?

Mr Cormack: That's not the direction.

Senator SINGH: Well, that's what is in the statement by the state and territory health ministers that this direction will result in the Commonwealth retrospectively not funding public hospital treatments and services that have already been delivered by states and territories.

Mr Cormack: That's the states' and territories' interpretation. That is not the minister's direction to the IHPA. I'll ask one of my colleagues here to explain in detail the nature of the direction, and we have the IHPA here, and the IHPA can explain what they would do and what they have done in receipt of such a direction.

Dr Hartland: It's not a matter of changing the rules, it's a matter of the minister seeking assurance that the rules have been correctly applied and that the data underlying that is sufficient to justify the increases.

Senator PRATT: The state government of Western Australia is seeking funding for Joondalup hospital, and I note that the member for Moore, Mr Ian Goodenough, who is a member of the government, has, 'Called on the federal government to contribute \$145 million in funding towards the \$312 million cost of expanding Joondalup health campus.' Has the Turnbull government committed any money to expanding the Joondalup health campus?

Mr Cormack: I'm not aware of any commitment that's been made above the existing National Health Reform Agreement payments and any other prior arrangements under the hospital and health infrastructure funds of the previous government.

Senator PRATT: So, as far as you're aware, this is not a policy of the current government?

Mr Cormack: I'm not aware of any additional funding commitment. Certainly something of that sort, of that quantum, would have been identified in the normal budget cycle, and it certainly hasn't been.

CHAIR: Good to see a local member fighting for his electorate. Let's move on to 2.1, mental health. Senator O'Neill, you have the call.

Senator O'NEILL: Thank you, Chair. Can the department confirm the amount of funding that's been allocated to the 12 suicide prevention trial sites?

Mr Cormack: I will have my colleagues join me, but it's \$3 million per site over three years—a million dollars per annum.

Senator O'NEILL: What's the breakdown of expenditure to date for each of the suicide prevention trial sites?

Ms Cole: We don't have breakdown figures to date. I can get that for you on notice for each of the 12 trial sites.

Senator O'NEILL: Thank you very much. Could you give me an indication of how much will be spent in each site for on-ground services and activities?

Ms Cole: Many of the sites are only just starting the commissioning process now. So it will be difficult to give you an estimate of that within the next three to four weeks. If we waited until perhaps March next year, I could give you a better picture.

Senator O'NEILL: Could you confirm if there were any guidelines given to the 12 PHNs outlining what that \$3 million in funding should be going to?

Ms Cole: Quite extensive guidelines were given to the PHNs around the suicide trials and what they needed to cover. However, they have a fair bit of flexibility in that the trials are meant to respond to local circumstances, to whatever gaps might be identified and also to have a coordinated and integrating role of services that are already on the ground.

Senator O'NEILL: Do the guidelines go to what the money should be spent on?

Ms Cole: The guidelines indicate the types of activities which a local community might wish to direct the PHN to some degree to do, to commission. The guidelines must, of course, be related to suicide prevention and be within an evidence framework. The guidelines do not dictate the types of activities that can be funded.

Senator O'NEILL: Is there an allocation in addition to the \$3 million to go towards administration for the trial sites?

Ms Cole: The PHNs already receive funding for mental health administration, and there was not a specific allocation within the \$3 million for administration of the trials.

Senator O'NEILL: Does that mean that, of the \$3 million, money could be spent on travel for participants to gather for meetings?

Ms Cole: Yes, it could.

Senator O'NEILL: So they're not getting that as additional funding?

Ms Cole: That's correct. The \$3 million is the total available for each trial.

Senator O'NEILL: So every time these groups have to meet, particularly if we're talking about Queensland or Western Australia, where we have huge distances to traverse, a very significant amount of money would need to be expended to get people together for the consultations—money that would not actually be going into services on the ground?

Ms Cole: That's correct. It affect some trials more than others. The trials are very different in terms of location. In somewhere like the Kimberley, for example, there will be some expenditure on ensuring that community members from places like Derby and Fitzroy Crossing and so forth are actually able to come to meetings to participate.

Senator O'NEILL: And that comes out of the \$3 million.

Ms Cole: That's correct.

Senator O'NEILL: There could be an awful lot of money to be spent on travel in such a region.

Mr Cormack: But it's important to understand the nature of these trials. The nature of these trials are that there is a degree of flexibility that enables local communities to co-design and put in place models that suit their local circumstances. We will not be dictating those from here in Canberra. Each of the 12 areas has different needs, and an important and valid part of the grant is to enable people to get together with the different community groups, the different agencies, the different consumer groups and communities to be able to design and

co-design the sorts of interventions that will work in their areas. So making a provision within that \$1 million for people to travel and work and plan their interventions is as valid as the intervention itself in terms of use of expenditure.

Senator O'NEILL: It may well be valid, but I'm trying to get some clarity. I think there's an expectation in the community and an understanding that the \$3 million is going to deal with the crisis of suicide in these communities and that the costs for travel, as much as that's an important part, would be in addition. Those are some of the understandings I've been given from the trial sites.

Mr Cormack: Travel is a valid part of both designing and delivering health care.

Senator O'NEILL: But it's a large cost to come out of the \$3 million for the Kimberley, in comparison to a small city area. That's a huge thing you're asking them to give up for an area that's in quite a considerable amount of need.

Mr Cormack: I guess it depends on how you interpret it. We don't see it as giving up something. It's actually a valid part of the co-design and the community engagement necessary to come up with the locally tailored solution.

Senator O'NEILL: But it's a cost to service provision on the ground.

Mr Cormack: It's part of designing the appropriate models of care that suit the local circumstances, and a valid part of that is making sure that stakeholders are able to get together to contribute to that co-design process.

Senator O'NEILL: I might put on notice why you haven't stipulated what the funding should be used for, given community expectation that this is about service change and trials of new services, not about covering the costs of travel, as much as that is an important part to get people together. The service provision is going to be different from place to place. I'd like a more fulsome answer on that. Could I go to the department to give me an update on the progress of each of the 12 suicide prevention sites, including population groups, locations, the list of steering committee working group members and whether on-ground services or activities have been commissioned? How quickly do you think you can do that?

Ms Cole: Would you prefer me to put it on notice, because it is quite a lot of information you've just asked for?

Senator O'NEILL: I think, in the interests of time, that we might need to do that, but I had hoped that you might be able to do it reasonably quickly, because it is just facts that probably are to hand. If there's any way you could get it before this evening's finished, that would be very much appreciated.

Ms Cole: I can run through this very quickly for you now. Are there any sites you would like me to focus on?

Senator O'NEILL: As I said, if there's any way you could get a tabulation of that together by 11 o'clock tonight, that would be great.

Ms Cole: Yes.

Senator O'NEILL: If there's somebody who can do that, that would be really helpful.

Ms Cole: How about I give you the memberships? The memberships are not the individual names; it's where they're from.

Senator O'NEILL: I was actually after the list of the steering committee members, the working group members.

Ms Cole: So, for example, the one for the Kimberley, which I just have here in front of me, we did actually give the actual names to you on a question on notice.

Senator O'NEILL: I'm trying to get the whole thing together in one go. If you can possibly dump that information into a document, that would be great.

Mr Cormack: Yes, we'll do that.

Ms Cole: We'll do that.

Senator O'NEILL: Thank you. Given that it appears that many of the on-the-ground services are yet to be contracted on most sites, is the government or the department considering that it might need to extend the trials?

Mr Cormack: Certainly at this stage, we're working within decisions of government, and those decisions of government are a three-year trial. We have no reason to question the need to extend those trials. Obviously, as the trials are further developed and implemented, we will be feeding back the results of evaluation processes to government, and that will inform future decisions of government in relation to expansion or revisions or changes to this sort of work. But at this stage, we're working within the decisions of government, which are 12 trial sites and \$3 million for each trial site over three years.

Senator O'NEILL: Technically, these trial sites are in their second year but some of them have only just advertised for a project officer. So in reality they're in their first year because there's been significant delay. Can you confirm that you have had no requests for an extension of these trials?

Ms Cole: I think most of the communities would like the trial period to be longer. However, that is not yet a discussion we have had with government. At the moment we have to work, as Mr Cormack said, within that three-year period, particularly for the evaluation.

Senator O'NEILL: That indicates to me that you have had requests from the trial sites asking for extensions. All of them or some of them?

Ms Cole: We have had some indications from some individual members of some of the steering committees and so forth that they would like to see the trials go for a longer period.

Senator O'NEILL: Would you be able to provide me details about that correspondence or those inquiries?

Ms Cole: They've been informal inquiries—just questions at meetings or similar things. I don't actually have a formal record of them that I can give you, but there have been one or two queries in meetings as to whether or not the trials could be extended, if that seemed appropriate towards the end of the time period.

Senator O'NEILL: Minister, are you aware of this problem?

Senator Nash: No, Senator, I'm not.

Senator O'NEILL: I think it's a real problem and definitely worth considering. I think it's more widespread than just one or two.

Ms Beauchamp: Senator, could I add that we're not starting from scratch. One of the prerequisites was looking at—

Senator O'NEILL: Sorry, but I'm having trouble hearing you.

Ms Beauchamp: In selecting the sites, one of the prerequisites was looking at the infrastructure available to support the site and, obviously, the target populations. In addition, the department has contracted key expert institutes and the like to help PHNs and others in making sure we can get cracking on the services and activities to be supported. The PHNs have been providing detailed proposed levels of activity as well. So there's a process going on in each of the trial sites, looking at access to existing infrastructure but also looking at contracting key organisations, like the Black Dog Institute or the European Alliance Against Depression, to help out some of the trial sites. We're looking at providing that level of information and support to these trial sites as well.

Senator O'NEILL: I understand that you're looking at giving support, but, given this collapse of time, surely getting meaningful data is also a concern to you. Again I ask: have any PHNs written to you formally—apart from the trial site participants or project officers—to say, 'We need more time. We're starting this late and we can't do quality data collection and analysis in the time you're allowing us.'

Ms Beauchamp: I'll take on notice whether we've been asked for an extension of time. I should also add we're in the process of engaging an evaluator to look at the sort of data that's being collected and to assess the trial.

Senator O'NEILL: So that's your strategy to deal with—

Ms Beauchamp: The data issue.

Senator O'NEILL: Are you doing that because you don't think there's capacity in the PHNs to do the data collection analysis?

Ms Beauchamp: If the government has invested a significant amount of money in a trial, it's incumbent upon us to make sure we can evaluate the efficacy of the trial.

Senator O'NEILL: Are there general criteria you're going to evaluate that everyone is aware of?

Ms Cole: There's a set of guidelines for the trials as a whole which are forming the basis, and then there's also agreed evaluation guidelines which were done in order to do the tender process.

Senator O'NEILL: So are the guidelines to be the instrument or are they just—

Ms Cole: No, there are evaluation guidelines, which link back to the original guidelines given to the PHNs about what had to happen in the trials and what was the scope and so on and so forth.

Senator O'NEILL: Is there a standard evaluation that's anticipated or is it going to vary from place to place?

Ms Cole: Because the trials are all different, particularly because of their locations and so forth, there's a sort of common theme that sits up the top in terms of how have they gone in responding to the local conditions and addressing the local conditions. They're using different methodologies. Some are using the Black Dog LifeSpan model, others are using the EAAD model—it's essentially the European Alliance Against Depression model—

Senator O'NEILL: Is that the Nuremberg model.

Ms Cole: yes, that's the Nuremberg model—while still others are using what is very similar to the LifeSpan model, which is essentially the WHO model.

Senator O'NEILL: When you put that data together in that data dump for me, would you be able to identify which one is using which methodology—or a blend of two by the sounds of things in some cases? Thank you very much.

Ms Cole: Yes, we can. In some cases there are. For example, in the Kimberley they're using the LifeSpan model and they're also using the modified ATSISEEP report in order to bring the two together.

Senator O'NEILL: Has the department given any advice to the minister in relation to the suicide prevention trial sites, around the time left for PHNs to carry out this vital work? Have you raised concerns with the minister?

Mr Cormack: Senator, we give regular updates to the minister—in fact, there is more than one minister involved with this—on a whole range of activities, including this one.

Senator O'NEILL: I'm sure that you do that. My question was: in those regular updates, have you given any information to the minister about concerns regarding the time left for PHNs to carry out this important work?

Mr Cormack: We haven't given that advice. At this stage the trials are underway. They're at different stages of development implementation. We're watching them closely. We've got an evaluation process about to begin to inform that. We will continue to keep the minister informed. If there are issues that arise that would cause us to suggest significant changes to the parameters, that will be the subject of advice to the minister and the government as required.

Senator O'NEILL: Could you take on notice how you're going to deal with getting the complete set of evaluations and a comparative set of evaluations when you've got such a significantly staggered start? Without adjusting that—it's a very significant and important question I think.

Mr Cormack: Sure.

Ms Cole: Yes.

Senator O'NEILL: Can you confirm that the funding attributed to the 12 suicide prevention sites includes the funding for evaluation? Is that another thing that comes out of their \$3 million?

Ms Cole: No, their funding for evaluation is separately identified.

Senator O'NEILL: Okay. So all travel and costs for travel are included in the \$3 million, but evaluation is in addition?

Ms Cole: For community reps only. Things like departmental officials travelling are funding separately. Equally, organisations like Black Dog, who may attend to provide further advice, are also funded separately.

Senator O'NEILL: With regard to the mapping of services, which is part of the work they're undertaking, how have you made sure that there is not a replication of the work that's already been done by the PHNs?

Ms Cole: The PHNs are generally working on the suicide mapping. Most of them had done it to some degree or other, and then there's an updating process and a checking process with local communities.

Senator O'NEILL: You're confident that there's no duplication of work?

Ms Cole: Yes, I'm confident there's no duplication.

Senator O'NEILL: In any of the 12 trial sites?

Ms Cole: That's correct, because it's always being done by the PHN. The difference, I guess, and the reason why we came back to do some of it again is because, for example, in the Kimberley they wanted to include cultural activities in the broad—including in schools, language, access, that sort of thing—which required another set of scanning, in a sense.

CHAIR: Senator O'Neill, can I just check—

Senator O'NEILL: I have a last one on the suicide prevention trial, and then I've got three other areas I want to prosecute.

CHAIR: Okay, but we're trying to knock this over not too long after five o'clock though.

Senator WATT: We're pushing a little bit later, because we think we will be able to massively cut back the outcomes tonight.

Senator O'NEILL: Why are the PHNs at such different stages?

Ms Cole: In part because it's when the announcements were made. They weren't all made in one go.

Senator O'NEILL: Who determined the timing of that?

Ms Cole: It was a decision of government. Some were announced in the election policy from the coalition. Some were announced prior to that, as lead agencies—the four original ones—and then the last three were announced towards December, January and February. I believe the last ones may have been announced by Minister Hunt when he commenced.

Senator O'NEILL: What's the time difference between the first announcement and the final announcement of the sites?

Ms Cole: I'll have to check, but it's between six and nine months.

Senator O'NEILL: Six to nine months. That's quite a significant amount of differentiation in timetabling. I'd like a response on how you're going to manage that because everybody is at a different point. Are there challenges there also in terms of mental health expertise that's available in these different regions? Is there a personnel issue?

Ms Cole: In terms of service delivery, Senator? Is that what you're asking?

Senator O'NEILL: In terms of the speed and capacity to respond. Are some starting slower because they're finding it difficult to get people to fulfil roles in particular contexts?

Ms Cole: It's certainly always harder for everyone in a remote location to find, for example, a project officer. To say that there aren't significant services in those areas and, therefore, expertise I think—

Senator O'NEILL: There are great people doing amazing work in regional and rural Australia, but I'm amazed by their resilience in the face of lack of access to resources

themselves. But my concern is: how much is that delay holding up the great need for response in those communities?

Ms Cole: I don't believe that is what it is. What I think is that the communities have engaged these trials very much. It's a very important issue to the communities. The two that I am involved in personally are the Kimberley and Darwin by being on the steering committee. In essence, what the community reps are saying is, 'Please go slowly and carefully because we want to make a fundamental difference to our communities in this area.'

Senator O'NEILL: Given that comment, I find it hard to accept that they haven't said, 'We need more time to do this properly.' That's what I'm hearing on the ground. They have made that very clear and I'm surprised the minister hasn't been apprised of that.

Ms Cole: As I said, this is why I'm aware and I said to you that one or two people had said to me that perhaps we need to be a bit closer. This is a related comment that I'm making to you, Senator.

Senator O'NEILL: I may have a few more questions on notice on that. Can I pop onto—

CHAIR: We'll come back to you, Senator O'Neill, but we'll go to Senator Siewert for a while. We also have some questions from Senator Roberts and Senator Kakoschke-Moore.

Senator SIEWERT: Before I start, I'd just like to acknowledge the work of Jackie Crowe, acknowledge her passing and give condolences. I think everybody will share in condolences to Jackie's family and acknowledge the amazing work she did as a commissioner. Could I follow up a discussion that we had during the last estimates around the commitment of the \$80 million. We had a discussion about it—a quite lengthy discussion about it—but you also took on notice some questions. In answer to one of them, you provided a comment that the minister had written to the states and territories on the matter of commencing negotiations. Could you give us an update on those negotiations, please?

Mr Cormack: Sure. The minister raised this issue with his state and territory colleagues, both in letter and in person. The COAG Health Council agreed to establish just a working group with the Commonwealth, state and territory governments to progress the measure. The first meeting was held on 21 September and the second one on 9 October. There has been a very good level of cooperation, and I think an emerging consensus, really, amongst officials about how the money might be distributed. There'll be a report back from that work to health ministers tomorrow week at the COAG Health Council meeting.

Senator SIEWERT: Tomorrow week?

Mr Cormack: 3 November. We envisage that, probably by end of the year, we will have the agreement parameters sorted out and we'll be able to commence the rollout of that measure.

Senator SIEWERT: Obviously there are follow-on questions from there.

Mr Cormack: Of course.

Senator SIEWERT: Is it your expectation that the parameters will be made public?

Mr Cormack: Yes, certainly. After the agreement has been sorted, we'll make those things available publicly.

Senator SIEWERT: The \$80 million question is: are the states going to be putting in a one-for-one? I understood that was the requirement.

Mr Cormack: Certainly the minister was absolutely clear that this was a co-investment arrangement with the state and territory governments. I think, as you would be acutely aware, Senator, some states are more progressive and more forward thinking in their investments in mental health.

Senator WATT: It's very kind of you to talk about Queensland as progressive. Excellent man—I knew I liked you!

Mr Cormack: All states shall remain anonymous.

Senator SIEWERT: Moving over the state and territory divide represented on this committee, let's progress.

Mr Cormack: Yes. I need to recognise that some states have already made significant forward allocations to psychosocial in a post-NDIS world.

Senator SIEWERT: Which states are those?

Ms Cole: New South Wales.

Mr Cormack: New South Wales is a good example. But we won't necessarily run through the list of all of them, because we're still working that through with our colleagues. The point is that it's not purely always a one-for-one, because, if a state had planned to completely disinvest and the Commonwealth comes in, brings in some additional money and they then are brought up to the level that they were prior to disinvesting, then it's not really a fair allocation. So we're recognising the efforts across the states to make sure—and also that the money needs to be distributed on a fair and equitable basis, which is very important.

Senator O'NEILL: Is it correct that the existing funding that the states are putting in is able to be counted towards the matched funding?

Mr Cormack: In some instances that would be the case, but not necessarily all, the reason being that some states—and I'm not going to go through a kind of league table—

Senator SIEWERT: Oh, go on!

Mr Cormack: Some states are still considering their position, and I would not want to pre-empt their own budget processes. Some states have clearly recognised this is an area where they continue to not only maintain effort but also grow effort, so we need to recognise that. Some are starting to realise that perhaps they may need to grow effort but have not necessarily gone through their own budget processes. So that's what we're working through.

Senator SIEWERT: Do I interpret that to mean there will be sort of a formula worked out on a state-by-state, territory-by-territory basis to work out whether that's satisfactory?

Mr Cormack: That's right. Ms Cole is the Commonwealth rep on the working group. We need to work out exactly what they're investing in at the moment and how that lines up with the Commonwealth's own investments, which are through Partners in Recovery and Day to Day Living, PHaMS et cetera. So there's quite a bit of, I guess, scanning and mapping work to be done before we can be entirely clear.

Senator SIEWERT: What happens if a state doesn't come on board by the end of the year? Do they miss out? Does the agreement stall?

Mr Cormack: The minister's made it very clear that, if a state does not wish to engage with this measure in good faith then the money can be redistributed elsewhere. That was

certainly an early comment, and I think the positive effect of that is that we're seeing a lot of goodwill. We're seeing a lot of states focusing on their forward funding commitments, which is exactly what I think the minister was attempting to do by putting the money on the table. We're confident that we're going to get to a fair and equitable agreement that recognises need but also effort from both levels of government.

Senator SIEWERT: And you're confident you'll get all state and territories. You're not prepared to out anybody yet?

Mr Cormack: No.

Senator SIEWERT: You're not prepared to out anybody, but you're confident you'll get the states and territories?

Mr Cormack: When we make it public at the end, if they haven't been able to reach agreement, then they'll clearly be outed.

Senator SIEWERT: I was wondering whether some extra campaigning is required in certain states.

Mr Cormack: I think the work at officials level is progressing really well. There's a report back to ministers next Friday, and I think certainly Minister Hunt will make very clear his expectations to his colleagues, and I'm sure that we'll see continued collaboration and forward investments result.

Senator SIEWERT: You mentioned that you'd been covering areas that may be covered by this funding or that you would be investing in. Are you able to share that with us now?

Ms Cole: The kinds of things that are being discussed in the broad are things like: what is the definition of services that will be covered by this measure? So, essentially it's psychosocial, but being quite specific that it's psychosocial for people who are not covered by the NDIS.

Senator SIEWERT: Yes, and it's not just about continuity of support, is it?

Ms Cole: That's correct.

Senator SIEWERT: It's for new people.

Ms Cole: That's right.

Senator SIEWERT: I just wanted to be clear about that.

Ms Cole: The second thing that's being discussed is the mechanics of how a state would show that they have put that additional investment in—so that sort of formula that we were talking about earlier, that Mr Cormack was mentioning. The third thing that's being discussed is the actual distribution of the Commonwealth funding and what the formula for that funding distribution is so that the states know how much they have to match by. That needs to be clear before they can come to an agreement. Finally, there's been a little bit of preliminary discussion about whether, if a state chose not to be in the scheme and it was redistributed, the remaining states would have to top up their commitment to the new funding.

Senator SIEWERT: For the additional funding that they would get?

Ms Cole: That's correct, yes. In essence, those are the kinds of issues that are being worked through at the moment, and they are close to resolution.

Senator SIEWERT: Are we talking about the types of programs that Mr Cormack articulated earlier that we're losing, like PIR and Day to Day Living? Are they types of services that we are talking about being funded?

Ms Cole: That's correct. Essentially they provide psychosocial supports at the moment, and it would be for that cohort of people who are not receiving that funding through the NDIS.

Senator SIEWERT: Was there an agreement on what happens in the awful situation a state or territory doesn't come on—

Senator O'NEILL: To those people?

Senator SIEWERT: Well, yes, to those people.

Ms Cole: At this stage we are reasonably confident that we won't have to deal with that issue.

Senator SIEWERT: Can I move on, because I'm going to run out of time.

Senator KAKOSCHKE-MOORE: Senator Siewert, just so you know, the questions you asked were what I was hoping to cover, so I don't need time in this space now.

Senator SIEWERT: Okay, thank you. In relation to the Mental Health in Multicultural Australia program, where is the targeted competitive approach up to and has a service provider been selected?

Ms Cole: We're currently in discussion. The process is finished and we're just in discussion with a possible provider.

Senator SIEWERT: Sorry. We have trouble hearing you. I apologise.

Ms Cole: Apologies, Senator. The tender process, the evaluation process, has been finished and we're currently in discussions with a potential service provider.

Senator SIEWERT: Does that mean, because you're still in discussions, you can't tell us who the successful tenderer is?

Ms Cole: That's correct.

Senator SIEWERT: When do you expect to be making the decision?

Ms Cole: Very soon.

Senator SIEWERT: Are you able to take on notice the process you've gone through and the time line you've gone through for the selection of the successful tenderer, rather than going through it now?

Ms Cole: Yes, I'm happy to do that.

Senator SIEWERT: Thank you very much. I've got a specific question—I'm just mopping up a few of my smaller questions—on the telehealth measure for rural and remote patients. I understand that a decision's been made that a percentage of those services have to be delivered face to face.

Ms Cole: Yes.

Senator SIEWERT: Has that always been—

Mr Cormack: It was part of the budget measures. Three out of the 10 need to be face to face. The other seven can be via a videoconferencing arrangement.

Senator SIEWERT: It's been put to me by people in my home state—which, as you know, is a third of Australia—that that is going to make it very difficult for some people in remote settings. Just say they're accessing services from Perth. Doing those face-to-face meetings from the Kimberley, for example, will be difficult.

Mr Cormack: I think that's a fair comment, and I think we need to put this in the context of what is in place now whereby they have to have all of their sessions face to face. In terms of a better deal for people in rural and remote areas, this is a 70 per cent improvement on the current arrangement.

Senator SIEWERT: We'd really like a 100 per cent improvement.

Mr Cormack: We think that, through the work we'll do with PHNs, there'll certainly be a lot of interest in this measure amongst health professionals, and we would like to think that with this new model available we might be able to encourage some better visiting services, better fly-in services, to enable that to take place locally. In other words, in some more remote areas, through this new funding measure from the Commonwealth, there might be a greater incentive for some health professionals to do a bit more travelling to be able to deliver the face to face.

Senator SIEWERT: So the funding would enable them to do that?

Mr Cormack: The fund doesn't pay for their travel. But we think that if they were able to generate a client base in an area that's been underserved, with the support they'd get from PHNs in terms of case finding, there would be an incentive—and we'll just see how the market responds to this—for some psychologists, social workers and others to invest in some regular visiting arrangements to discharge the face-to-face responsibilities of a client group in a particular area, knowing that 70 per cent of the MBS entitlements they're going to discharge with those people can be done remotely from their city base or regional office base. So it's a lot better than what we've got in place at the moment.

Senator SIEWERT: I've got one more question there and one other question I'd like to ask before we move on. How was the number picked? How did we get to 70 per cent instead of 100 per cent?

Mr Cormack: It's a decision of government in the budget context.

Senator O'NEILL: Savings.

Senator SIEWERT: This was supposed to be about providing better access, so if this is going to restrict access—

Ms Cole: There were a couple of things we were weighing up in the advice on this one. The first one is that in many cases it is better to do a face-to-face session if you can. We didn't want to have a situation where you had big services in Melbourne, for example, providing services right across Australia and there was never any actual personal interaction between the client and the practitioner. So that was one thing we wanted to avoid.

Secondly, we wanted to make sure that we weren't destroying the business model of people who did actually work in regional centres across Australia. So for those people, who may already be doing outreach services, this gave another mechanism. It meant that people could come into a regional centre but do the majority of their services by Skype, once they've got that personal connection in place. That was why there was the rule that one service in the first

four must be face-to-face and then only seven of the 10. So they were the considerations that were taken into account.

Senator SMITH: Is Ashcliffe one of the representations that has been made to you on this issue?

Senator SIEWERT: Yes.

Senator SMITH: So I'd give that a score of two out of three, because in Australia we have metropolitan, regional and then generally rural and remote. What's the answer for rural and remote?

Ms Cole: That's where we need to look at innovative service models. For example, I was talking to the RFDS not long after this was announced and they were talking about how they could use their services where they're taking GPs out to very remote communities on a regular basis and they could take a psychologist at the same time who could then do the follow-up work with that client group through telehealth.

Senator SMITH: Why wouldn't we design the program in a way that better reflected the unique circumstances of remote and rural communities rather than trying to develop an add-on to do that? Wouldn't it make more sense to provide some flexibility around the program guidelines?

Ms Cole: This is a Medicare item, so that makes it a little bit less flexible than some of the other services which are already being put in place by PHNs. They can potentially provide all of their services through a telehealth arrangement. Western Australia, for example, already has that in place through the Country WA PHN for very remote communities.

Senator SMITH: Would you be open to exploring some of those specific Western Australian concerns that have been raised with Senator Siewert and myself—putting the metropolitan and the regional aside—about the representations that have come to us specifically around the genuinely remote and rural aspects of this?

Ms Cole: I'd be happy to provide you with further information about what the PHN is already doing in this scenario.

Senator SMITH: That would be a good first step, but that might not be a satisfactory end step.

Mr Cormack: We're operating within a decision of government which has really given a big boost to access to these services for people in regional, rural and remote Australia. Ms Cole has outlined some opportunities with other programs where we might be able to innovate some of our other programs to leverage them to be able to better respond to some of those in really remote locations. We're happy to look further into that. We've got to operate obviously within the Medicare rules that apply to these items, but there are other mental health program funds and other primary healthcare funds that we use in rural or remote areas, and we'd be very keen to have a further look at that to see what can be done to recognise the extreme remoteness that you're talking about.

Senator SMITH: In developing the program, what priority or particular emphasis was given to rural and remote experiences?

Ms Cole: This program was always set up to be a rural and remote program, which is why it's only those that are in the Modified Monash Model that are eligible.

Senator SMITH: We might take the department up on that offer.

Senator SIEWERT: That would be good.

Ms Beauchamp: Can I clarify the comments I heard earlier about outcome 1. I've just about got the Digital Health Agency get on the plane from Sydney for outcome 1. I just want to confirm that there are no questions for outcome 1?

CHAIR: Senator Griff has said no and Senator Watt did confirm that he had no questions.

Senator SIEWERT: He did just then.

CHAIR: Okay, then outcome 1 is released.

Ms Beauchamp: Thank you. I'll let them know.

Senator DUNIAM: I'm sure they'll be disappointed!

Senator SIEWERT: Yes, they'll be really sad! You may need to take this on notice. I asked this in the Department of Social Services yesterday and they said to ask Health. As you may recall, there was a package of measures that were rolled out to help people affected by forced adoptions, and part of that package included training for psychologists specifically around forced adoption. They were then to prepare a list of the people that had been trained so that people requiring specialists could find people that had been trained on forced adoptions. I have had contact from people that have indicated they're finding it hard to find that list. In fact, they don't know if it was ever developed. Are you aware whether that list was actually developed? As I understand it, it was APS that was supposed to be doing it.

Ms Cole: DSS did let me know that you were going to ask this question. Essentially, we do not have in our records any requirement for the APS to develop a list. They have developed the training and engaged with a number and 563 clinicians have actually complete that training. I understand the point that you're making, so I'll have a separate discussion with the APS and see whether it can be—

Senator SIEWERT: Can you please. I was a part of that reference committee. I was know there was a commitment to do that.

Ms Cole: Yes. We'll see whether we can retrospectively fix that issue for you.

Senator SIEWERT: That would be appreciated because, as I said, people are finding it hard.

Ms Cole: Yes, I understand the issue.

Senator SIEWERT: It's hard to find somebody with the skills and the understanding, and that was why the commitment was made in the first place.

Ms Cole: I'll talk to the APS and perhaps report back to you on notice as to how we go.

Senator SIEWERT: That would be really appreciated.

Senator ROBERTS: I want to acknowledge Richard Hopkins's work on the RESET campaign on medicinal cannabis. Earlier today Dr Skerritt said that the key person prescribing medical cannabis is the prescribing doctor, but in fact under your system the prescribing doctor, I'm advised, can only make a recommendation that a patient should receive medicinal cannabis. So you make the final decision. Why do we not give the decision to the key person, the prescribing doctor who knows the patient?

CHAIR: Sorry, this is a bit out of scope, isn't it, Senator Roberts? We're in mental health.

Senator ROBERTS: I understand that.

CHAIR: Are you going there?

Senator ROBERTS: Yes. It's been seen as highly effective for people with mental health problems.

CHAIR: Can we perhaps stick to those issues here because we did cover this issue quite extensively in the general section this morning.

Ms Beauchamp: We could cover it when the regulator is on at eight o'clock—or forecast to be on at eight o'clock.

Senator ROBERTS: Eight o'clock? See you then.

CHAIR: Thank you, Senator Roberts. Very efficient.

Senator O'NEILL: I will ask a couple of clarifying ones around the working group who were developing the criteria for the state and territories with regard to the psychosocial support scheme. I was listening carefully. Who is on the working group, Mr Cormack?

Mr Cormack: There are representatives from each jurisdiction, and Ms Cole chairs that. They've had two meetings already. There's a report to ministers on Friday week at COAG Health Council, and we envisage that the paper seeking endorsement and agreement of those terms and conditions will be settled in December so that the measure can get rolled out.

Senator O'NEILL: Could you tell me if the criteria has been developed?

Ms Cole: The main elements that are being discussed in that group are essentially how the Commonwealth funding is distributed between each state and territory and the formula for that; and the definition of what is meant by psychosocial support, which is very important in terms of defining the matching funding from the state and territory.

Senator O'NEILL: There's a great deal of interest in it.

Ms Cole: That's right. Essentially the definition is coming out as a normal definition for psychosocial support minus those who are in the NDIS or receiving services through the NDIS.

Senator O'NEILL: Could I ask if you could provide on notice the names of the people on the working groups and the criteria that's developed.

Ms Cole: Yes.

Senator O'NEILL: Will that be released publicly?

Mr Cormack: We envisage that when the agreement is settled and sorted it will be publicly released.

Senator O'NEILL: And nothing before then?

Mr Cormack: When you're in the process of negotiating agreements between governments, the normal practice is to work through the agreements, get them settled and then make the necessary announcements.

Senator O'NEILL: And that will be done by the end of the year?

Mr Cormack: We envisage that in December we should be ready to settle the terms and conditions of that.

Senator O'NEILL: For commencement by what date?

Mr Cormack: The funds are available from this financial year, so we would certainly be commencing the work as soon as possible after the signing of the agreements.

Senator O'NEILL: So would that be January or February or March?

Mr Cormack: Yes, probably around the first quarter of 2018.

Senator O'NEILL: Could I just ask a couple of very quick questions about the ABS mental health survey which was undertaken, as I understand it, in 2007 and 1997. It is happening on a 10-year basis from what I could discern. That means it would be due this year. What's the status of that?

Ms Cole: At the moment, we're just doing some scoping studies around what would be included and so forth with a view to then being able to go out to market in due course.

Senator O'NEILL: Go out to market when?

Ms Cole: In due course, so perhaps towards the end of this year or early next year, just depending how long it takes us to get agreement among the experts about how the survey will be constituted in order to be able to go out to the market.

Senator O'NEILL: Will you keep it sufficiently similar so longitudinal analysis can be done and add in new insights?

Ms Cole: That will be part of the discussion we need to have in defining the criteria.

Senator O'NEILL: Have the ABS confirmed they have got sufficient funds to do this?

Ms Cole: No, this is funded by the health portfolio.

Senator O'NEILL: So is it guaranteed it will go ahead? When do you expect the publication of those results?

Ms Cole: Last year it took over two years.

Senator O'NEILL: So not until 2019 or 2020?

Ms Cole: It will depend on how the information is gathered, how long it takes and who does it. So that will obviously be part of the consideration when we go out and test the market on this one.

Senator O'NEILL: We waited for a really, really, really long time for the fifth national mental health plan to come out and, given how long everyone had waited, I thought there'd be some incredible fanfare but I was sadly, totally underwhelmed. Is the fifth mental health plan actually operational?

Mr Cormack: The fifth national mental health plan was settled at the last COAG Health Council meeting in August, agreed by all ministers. And Minister Hunt, on the final day of Mental Health Week, made some public statements around the fifth national mental health plan. The more important thing you're referring to is the implementation.

Senator O'NEILL: Can I clarify first: is the version that's on the website the actual final version?

Mr Cormack: That is correct. The one on the COAG Health Council website, I think, is up; I'll just check. I think it's up on our website.

Senator O'NEILL: There's uncertainty in the sector if that's the final one because there was actually no launch for this.

Mr Cormack: It was announced, as I said, at the August COAG Health Council meeting and the final version of the plan and the implementation approach was put up on the COAG Health Council workshop about a week-and-a-half ago, from memory—I'll check the date—and that's the version. Certainly the stakeholder groups that were part of that would be aware that the plan has been finalised.

Senator O'NEILL: Why was there such an extended delay between the endorsement of the plan and the announcement by the minister, which we can't really call a launch?

Mr Cormack: There were just some timing issues with the COAG Health Council secretariat. There were some printing and type-setting arrangements that had to be attended to. We needed to consult amongst jurisdictions just briefly around the timing of release of the plan. But I think the more important point is the group responsible for the implementation has already met, about a month ago, to progress the implementation, which is, I think, probably the most important part of that.

Senator O'NEILL: So to be clear, the delay had nothing to do with anything other than just practical problems of printing and type-setting; is that it? Is that all it was?

Mr Cormack: Effectively, the implementation process began after the ministers agreed to the plan. They requested that AHMAC, through the mental health principal committee, progress that implementation. That work started more or less straightaway, and it preceded the publication of the plan on the COAG Health Council website.

Senator O'NEILL: Given its importance, I'm really surprised that was the case. Could you advise me about the funding allocated to support the outcomes of the Fifth National Mental Health and Suicide Prevention Plan?

Mr Cormack: The fifth national mental health plan is a policy framework and an agreed set of priorities between the Commonwealth and the states. It is intended to guide the efforts and coordinate the efforts of the Commonwealth funded sector, the state and territory government sector and the NGO sector—

Senator O'NEILL: I understand. My question is about the funding. I have probably five minutes.

Mr Cormack: It does not have a specific funding allocation associated with it. There is already—

Senator O'NEILL: There's zero dollars?

Mr Cormack: No, that's incorrect. The plan is meant to guide the funding efforts of the Commonwealth. We already spend over \$4 billion a year on mental health. This is meant to guide and coordinate our expenditure with that of the state and territory governments around the themes outlined in the plan. That was its intention. In fact, that was the practice with the previous national mental health plan. It is an agreed policy framework between the Commonwealth and the states that guides investment. It's not a formal Commonwealth-state national partnership agreement or funding arrangement.

Senator O'NEILL: I understand why there wasn't fanfare around the announcement of the policy now. There are eight additional priorities, eight significant priorities. How can that plan be implemented without additional funding?

Mr Cormack: It's been implemented already through focusing existing funding around those agreed priority areas. That's its purpose.

Senator O'NEILL: I'll put the rest of these questions on notice.

Senator WATT: With the government's postal survey regarding marriage equality now distributed, is the department aware of any spikes in demand for counselling or trauma services accessed by members of the LGBTIQ community?

Mr Cormack: We have obviously been monitoring the number of contacts to our funded digital mental health services that offer telephone or web based counselling services in this context. We certainly work closely with the sector on a whole range of issues, including this one.

Senator WATT: And have you noticed any spikes in demand having monitored those mechanisms?

Mr Cormack: Across the funded services, most have not experienced any significant change in the levels of demand, but we'll keep closely in touch with them, and, if there's any further advice or any further need to act on that—as we do, because, at different times of the year, there can be other circumstances in particular communities that can lead to changes in demand. The Commonwealth and, indeed, our PHNs, as commissioning bodies, work closely with a range of organisations to monitor the level of demand for services and respond accordingly.

Senator WATT: Did you say that, in the groups that you've been monitoring or have been in contact with—have you made any inquiries with service providers in relation to any increase in demand for services as a result of the postal survey?

Mr Cormack: Yes, we have.

Senator WATT: You said there's been no significant increase.

Mr Cormack: For most of them it's business as usual.

Senator WATT: Have any service providers approached the department or the minister's office to raise concerns around an increase in demand for their services.

Mr Cormack: You'd have to ask the minister's office about approaches to the minister's office.

Senator WATT: Sure.

Mr Cormack: As I said to you before, we are in regular contact with our funded organisations and continue to monitor the situation, as we do right throughout the year for a whole range of other reasons.

Senator WATT: What about LGBTIQ-specific services—services that are specifically set up to assist that community, particularly with mental health support?

Mr Cormack: Yes, we have been in touch with the services that look after that client group.

Senator WATT: They're telling me they haven't had a significant increase.

Mr Cormack: No, they have indicated that there has been some increase in contacts, but, across the range of service providers—and we have, I think, over a dozen different service providers in this space—there hasn't really been any significant spike reported to us.

Senator WATT: For instance, there's a group called Qlife. Have they had contact with the department, and what have they advised you in this regard?

Mr Cormack: They have been in contact with the department, and they have advised that they have had an increase in the number of contacts.

Senator WATT: How have they characterised that increase?

Mr Cormack: For specific information we have to take that on notice, because we haven't got the stats with us. But they have indicated that they're monitoring it very closely. That organisation put some guidance materials on their website for people who may have concerns during the period of the postal survey. We have kept in touch with them, but we don't have any statistics or information available with us today.

Ms Beauchamp: Can I also add: that doesn't necessarily correlate with a request for additional funding. For example, I think the government provided \$2.9 million extra in the budget for that organisation you just mentioned.

Senator WATT: Has the minister made any request to the department for any advice or any additional funding for counselling or trauma services for members of the LGBTIQ community?

Mr Cormack: The minister has just asked us to keep an eye on any area in mental health, as he's very in touch—

Senator WATT: What about this specific area of mental health?

Mr Cormack: He's asked us to keep an eye out for that, and we haven't received any specific requests for increased funding or resource requirements from frontline services.

Senator WATT: I don't know if you're aware, but the Leader of the Opposition recently wrote to the Prime Minister about this very issue. Has the department seen that letter?

Ms Cole: We believe that letter is publicly available.

Senator WATT: Have you been asked to provide advice in relation to that letter, or to draft a response?

Ms Cole: No, but I believe that that is likely to be a question you should direct to PM&C.

Senator SIEWERT: Last estimates, we had a discussion about the PIR in the ACT and the issues around the specific nature of ACT moving more quickly to full rollout. How many of the clients of ACT Partners in Recovery are yet to seek access to the NDIS?

Mr Cormack: I think we might need to take that one on notice. We don't have that information available.

Senator SIEWERT: That would be appreciated, thank you. We have had an ongoing discussion, both here and in aged care, about access to mental health services in aged care. At the last estimates we had a discussion, and I was given information on notice about access to CDM. I appreciated the information, but I note that for 137,684 CDM allied services provided, only 369 were for mental health. That's not proving as effective as one would hope, so I want to go back to the issue around better access and ask what progress has been made in looking at how better access can be used to address this issue?

Mr Cormack: We've continued to do some work on the issue, and we're working through the information that we've got around levels of need. Obviously, that information that we

provided to you is part of that exercise. At this stage, it's an ongoing discussion with government. They're certainly aware of the issues as we discussed last time, but it's a matter for consideration by government.

Senator SIEWERT: I'll be really quick, and you may need to take some of these on notice. The research that you're doing, there is an established agreement that there is a significant issue in older Australians, particularly those in aged care, around mental health. Can I ask you take on notice to give me the details of the research that you're doing on that—who's undertaking it and the time line for completing that?

Mr Cormack: Sure. We're happy to take that on board.

Senator SIEWERT: In terms of the nature of what happens after that, what's the time line for that?

Mr Cormack: It's a decision for government. That's all I can say. You understand the way the Medicare items are currently set up and the way the rules are. Any changing or modification of that would be a policy decision for government.

Senator SIEWERT: Have you done work on the possible changing of the rules?

Mr Cormack: As I said, we've undertaken quite a bit of work to get a better understanding of the need. We're looking at that advice. We'll continue to provide advice to government. That's a matter for government consideration.

Senator SIEWERT: Can you not answer the answer specifically? Have you provided advice on the change to the rules?

Mr Cormack: I think I've answered the question.

Senator SIEWERT: Have you?

Mr Cormack: I believe I have.

Senator SIEWERT: Believe you have provided information to the government about that?

Mr Cormack: Yes. We provide information to government about a whole range of issues, and this is one issue, as we indicated last time. It was a matter of active consideration. Should there be any change, that would be a matter for government consideration.

Senator SIEWERT: Is it acknowledged that CDM is not providing the level of support necessary to properly address mental health?

Mr Cormack: I think there are opportunities within the existing CDM program to be able to perhaps look at whether that can be made more widely available. There's obviously an uptake issue, and I think that's one of the things that we're looking at, as to whether the existing arrangements within that suite of Medicare items could be better utilised. Clearly, as the advice we provided to you indicates, it's a relatively low level of utilisation, and that's an area of further development.

Senator SIEWERT: I'd say extremely low.

Mr Cormack: We'd certainly be looking to our PHNs to have a look at what they can do to, you know—because these are triggered by general practice consultations, and clearly there's some work we will do with the PHNs to make better use of an existing government program.

Senator SIEWERT: I'll follow it up next estimates. Thank you.

Senator ROBERTS: In March 2013, the National Mental Health Commission announced a partnership with the Mental Health Commission of Canada. The two countries signed a memorandum of understanding, and agreed to share knowledge on best practises for mental health research. The Marijuana for Trauma organisation now has 11 clinics across Canada, treating literally thousands and thousands of patients. Are you monitoring this proven, successful strategy?

Mr Cormack: It's probably best if we ask the Chief Executive Officer of the National Mental Health Commission, Dr Peggy Brown, to talk to that item.

Dr Brown: It is not something that we have been actively monitoring in recent times, but I am actually attending a meeting with the Mental Health Commission of Canada in two weeks time, and I'll certainly raise it there.

Senator ROBERTS: Would you be able to let us know how that goes?

Dr Brown: I'd be happy to do that.

Senator ROBERTS: Is the National Mental Health Commission devoting any resources to studying the role medicinal cannabis can play in the treatment of mental disease?

Dr Brown: No, that is not on our current work plan. The National Mental Health Commission, by and large, focuses on mental health and suicide prevention. It doesn't have a mandate currently to look into drug and alcohol. I know there is a crossover and I know from your earlier comment that you're clearly interested in people who have mental health conditions and the use of cannabis in that. But it's not something that's on our work plan or in previous work plans.

Senator ROBERTS: Are you aware of the studies that show medical cannabis to have antidepressant and anti-anxiety properties?

Dr Brown: I am certainly aware of claims around anti-anxiety. I have less knowledge of antidepressant claims. I think there are many claims being made about medicinal cannabis, some of which don't necessarily have a strong evidence base at this point in time.

Senator ROBERTS: There is certainly a lot of anecdotal evidence and, I believe, overseas some scientific evidence as well, not just some, but quite a bit. Why is the only mention of medical cannabis and mental health on your website one that links marijuana use with mental illness, even though internationally medical cannabis has been approved to treat many conditions?

Dr Brown: I think the scientific literature shows there's a fairly strong association between the use of cannabis and the development of mental health conditions in those who probably have a predisposed vulnerability to developing a mental illness. I think that, with the advent of interest in medicinal cannabis, we're talking about a different type—well, a different formulation of the cannabis.

Senator ROBERTS: That's a good word.

Dr Brown: That's a fairly recent development in Australia. And, as I said, it's not one that the National Mental Health Commission have had a focus on to date.

Senator ROBERTS: It's one that seems to be building quite a head of steam.

Dr Brown: Well, as I said, I think there's a lot of interest in various aspects around medicinal cannabis, and it's one that we can have a look at. But it hasn't been on our work plan to date. We've been focusing on other significant aspects of mental health reform around the country.

Senator ROBERTS: You'd be aware of research that says antidepressants can cause long-term depression? Isn't the term 'tardive dysphoria'—is that it?

Dr Brown: I am not personally aware that antidepressants cause long-term depression. I think there is a lot of speculation around the use of medications.

Senator ROBERTS: There are a lot of uncertainties around the use of those drugs too, aren't that?

Dr Brown: Well, there's uncertainties around the use of antidepressants, antipsychotics et cetera. There's also a lot of evidence about the effectiveness of them for treatment. But it's not a pure science.

Senator ROBERTS: No.

Dr Brown: And, as I said, I don't think there's a wealth of science yet in terms of medicinal cannabis either. It's early days in terms of building the evidence base.

Senator ROBERTS: But, if there is research saying antidepressants can cause long-term depression—and there is quite a bit of uncertainty, as I understand it—and certainly some benefit from antidepressants, wouldn't that still be a reason to expedite medical cannabis trials, which have been shown to have positive outcomes for treating depression?

Dr Brown: I would have to take some further advice in relation to the evidence that you're referring to.

Senator ROBERTS: Okay. Should we provide that?

Dr Brown: If you wish to provide information to us, we'd certainly be happy to come back to you with some further thoughts in relation to that.

Senator ROBERTS: So you'll take it on notice once we give it to you. Thank you very much.

CHAIR: Senator Roberts, how much longer do you think? A couple more questions?

Senator ROBERTS: Two at most.

CHAIR: Good.

Senator ROBERTS: Aren't there studies that show depression patients receiving a placebo were less likely to exhibit a recurrence of their depression than patients taking actual antidepressant drugs, by almost two to one?

Dr Brown: Again I'd have to look at the specific study you're referring to. There's certainly a lot of studies that would indicate the reverse; those who receive antidepressant medication actually are less likely to have a recurrence. So, again, there may be a study that shows the outcome you're referring to but I don't think on balance that would be the more common outcome.

Senator ROBERTS: Okay. Is the National Mental Health Commission following the trial of medical cannabis for paediatric depression and anxiety being conducted at Lambert initiative in Sydney and will you undertake to include that data in your upcoming reports?

Dr Brown: As I said, the National Mental Health Commission aims to monitor and report on suicide prevention and mental health systems. More broadly, we are a small organisation and there are many different aspects on which we could report. Going down to the specifics of medicinal cannabis for paediatric anxiety and depression is probably a level of granularity beyond our capacity.

Senator ROBERTS: Who would be the people to do that?

Dr Brown: I think you'd probably be better to either go to the college of psychiatrists or perhaps the paediatricians and speak to them about that.

Senator ROBERTS: Okay. Thank you.

[17:36]

CHAIR: Thank you. There being no objections, we'll release outcome 2. We will move on to outcome 6, ageing and aged care. Senator Polley, you have the call.

Senator POLLEY: Could I just start with some questions as an overview to lead in to the others. This really requires just very simple answers, so it won't take very long to get through. Has the government formally responded to all the recommendations of the alternate aged-care assessment classification system and funding models undertaken by the University of Wollongong?

Ms Rule: No, the government has not. So—

Senator POLLEY: Okay. That's good. Has the government formally responded to the recommendations of the aged-care legislative review undertaken by David Tune?

Ms Rule: The government has responded at a global level to say they've ruled out two recommendations and that they'll consider the rest of the recommendations in coming months.

Senator POLLEY: Has the government formally responded to the review of the aged-care funding instrument undertaken by the applied aged-care solution?

Ms Rule: No.

Senator POLLEY: Has the government formally responded to the findings of the base interest rate study undertaken by the Aged Care Financing Authority?

Ms Rule: No.

Senator POLLEY: Has the government formally responded to all the recommendations of the review of the national aged-care quality regulatory processes undertaken by Kate Carnell and Professor Ron Paterson?

Ms Rule: The government has respond to say they will move to implement recommendation 8 of that review and that they will consider in detail the rest of those recommendations.

Senator POLLEY: In the coming months?

Ms Rule: Yes.

Senator POLLEY: Has the government formally responded to all the Aged Care Sector Committee's views on the short-, medium- and long-term actions detailed in the *Aged Care Roadmap*?

Ms Rule: No, but it's not the kind of document that government would be expected to respond to.

Senator POLLEY: We have had six reviews and reports, and we've got a response to two points.

Ms Rule: I think some of the reviews that you've raised, particularly the ones around funding, are inputs to the David Tune review, so it's important to be clear that some of those reports are inputs into broader processes. And the Tune review is one of those ones that government has responded to parts of and indicated the pathway to respond to the rest.

Senator POLLEY: Yes. But the government has had those reports for some time, including David Tune's?

Ms Rule: They're not stand-alone reports, though, Minister—Senator. They are inputs into a broader review.

Senator POLLEY: Not quite 'Minister', yet.

Ms Rule: Sorry.

CHAIR: I'll be working hard to prevent that, as much as I love you.

Senator POLLEY: You can always live in hope.

Can we then move on—if that's okay with you, Chair—to 6.1?

CHAIR: Absolutely.

Senator POLLEY: Or do we want to just go through this?

CHAIR: I think it's a relatively small outcome, so we'll just roll everything together. I know Senator Griff has some questions for the agencies, but you've got the call.

Senator POLLEY: Excellent. I'd like to move to ACAT and RAS assessments and the delays. We've actually questioned the delays over the last few estimates. In response to question SQ17-000826 you reported that at 31 December 2016—

Ms Buffinton: Sorry, Senator, I'll just turn to that same question—could you just repeat that again, please.

Senator POLLEY: SQ17-000826. In that, you reported that at 31 December 2016 only 68.8 per cent of ACATs were meeting contact requirements for high-priority clients and that 91.2 per cent for medium-priority clients and 79.5 per cent for low-priority clients. Can you provide an update as of 1 July this year?

Ms Buffinton: Yes, I can. Yes—sorry, would you like to ask the questions, and I'll then follow through?

Senator POLLEY: I just asked the question. Can you give us an update through to 1 July this year? The last time you responded was back in December 2016, so we would like an update.

Ms Buffinton: Yes, I can sort of step through that. On a national basis: at the end of the financial year, for high priority, we were running at 71 per cent compared with 68.8 in the last; we were running at 92 per cent for medium priority; and we were running at 76 per cent for low priority—remembering that that is the indicator of the first clinical intervention, so that's the first contact.

Senator POLLEY: Can you tell me, then, which of the states currently have the longest waiting times for ACAT and RAS assessments?

Ms Buffinton: Let's start with ACATs because that was the area where we were particularly concerned. In terms of wait times, there's been a strong improvement. Just to remind: we did have an improvement schedule. We asked each state to give us an improvement schedule on their work. Assessments that are open for more than 75 days we put as a formal benchmark for this financial year. First of all, in terms of those that are open by jurisdiction, you'll be pleased to know, for example, in your state of Tasmania that whereas in May there were 89 assessments still open with more than 75 days, that was down to one assessment open for more than 75 days.

Senator DUNIAM: That's great news.

Ms Buffinton: Many of the states have made major improvements after we've both gone out and spoken to them. We've sent out people to share best practice, and the minister also wrote to his counterpart health ministers to make sure that there was a focus on improving ACAT performance.

Senator POLLEY: So it was just a matter of having a conversation with him?

Ms Buffinton: No. We began in February, where we've gone out and spoken. It's been six months. It's still a work in progress, but by May they all had to submit a work plan. Whereas there was a lot of concern in the community, and we shared that concern, there's been a lot of improvement.

Senator POLLEY: Is that also for Queensland and South Australia?

Ms Buffinton: Indicative in Queensland in May there were 1,479 assessments beyond 75 days, and by September it was 127.

Senator POLLEY: To save a little bit of time would it be possible to table a copy of what you're reading from? That would probably save some time.

Senator DUNIAM: That would be an idea.

Ms Buffinton: Yes, that's fine.

Senator POLLEY: Excellent. What is the situation with RAS? Or, again, have you got a table?

Ms Buffinton: We could provide a table on RAS as well. Again, RAS, we've never had that same level of concern. ACATs were our concern. RAS have been timely. We've had a couple of providers of concern. Because they're on a contract we can have a much faster direct engagement with them to getting them to focus on improving.

Senator POLLEY: Okay. That sounds good. The Tune report provided feedback that the ACATs are a potential factor into the perceived wait times for home care packages, and consumers' future needs into their assessment decisions. Have you investigated this claim? I'm sure you've read the Tune report.

Ms Buffinton: Where somebody appears on the queue, as I think we might have discussed previously, when a person first gets their ACAT assessment and goes into the system, that begins their clock. That's when they enter the system. So, if you don't have a timely ACAT assessment that can hold up when you enter the system and therefore that just adds to how

long you'd need to wait before you get a home care package. So, yes, we have. That's part of the reason why we've been very focused on ACATs.

Senator POLLEY: Right. What do you take from the comments from Mr Tune in his report, as far as ACAT and RASs are concerned?

Ms Rule: The Tune review makes recommendations about the approach to assessments. But, as I said previously, the government is still considering those recommendations and no decisions have been made yet.

Senator POLLEY: Have you made any recommendations to the government?

Ms Rule: I'm not at liberty to share the advice we have given—

Senator POLLEY: I am not asking what advice you gave them. I'm asking if you have given advice?

Ms Beauchamp: We're working with the minister and other portfolios in the context of developing a more formal response, but the government has already announced its position on two of the recommendations. I think they're quite broad, and I think in the context of what the government is doing around ageing we're certainly consulting other agencies in terms of putting advice to government.

Senator POLLEY: Is the government planning to extend the current ACAT contracts through to 1 July 2020, in line with the commitment to extend RAS contracts?

Ms Rule: There's no plan in place for that to occur at this time.

Senator POLLEY: There's no plan to do that. You haven't given any advice to the minister in regard to that?

Ms Rule: Not at this stage.

Senator POLLEY: Are you considering giving advice to the minister on that?

Ms Beauchamp: We're currently considering options beyond 2018 and, of course, performance is one of those. Whilst ACAT assessments have been trending down, in terms of wait times, we need to make sure that we've got a good framework if our advice to government's going to be considering funding beyond 2018. We're currently in the process of considering and working with the minister on that.

Senator POLLEY: Is there any work being done in relation to the current RAS providers, or any other private providers, to deliver some or all of the ACAT services?

Ms Rule: No.

Senator POLLEY: Why not?

Ms Buffinton: At the moment we have two distinct systems. We have the aged-care assessment teams, the ACATs. They are currently on contract through to 30 June 2018. And we currently have our contracts in place with the RAS that currently go through to 2018—but, as you say, for those that were tendered in 2015 the government has announced that they will be extended to 2020.

Senator POLLEY: Right. So there are no plans in place to change or to put in any safeguards or to put out any tenders for private providers to do any of that work?

Ms Rule: No.

Senator POLLEY: Okay. Recommendation 27 of the Tune review calls on government to integrate their RAS and ACAT workforces. This recommendation is in line with the aged-care road map and was described in 2015 by the then minister responsible for aged care, Senator Mitch Fifield, as the next logical step. Is the integration government policy, and what work has government done to progress this recommendation?

Ms Rule: As per my previous answer, the government has ruled out two recommendations and is actively considering the others, of which recommendation 27 is one.

Senator POLLEY: The then minister in 2015 said it was the most logical step to take. We're in 2017, and the department has done no work at all on working out an option?

Ms Beauchamp: I don't think the officer said the department has done no work. I think Ms Rule was saying that we are looking at—

Senator POLLEY: I'm sorry, I can't hear you.

Ms Beauchamp: I don't think we said that we've done no work. I think we're sort of saying we haven't got a formal government response yet. So we're working through those recommendations, minus the two that the government has already responded to, in assisting government develop its response.

Senator POLLEY: So what sorts of options and planning and work have you done thus far?

Ms Beauchamp: I prefer not—well, I won't go into the detail of that. That's obviously between the department and the office.

Senator POLLEY: But you haven't given any advice to the minister and so you can't outline in general terms what it is that you're looking at?

Ms Beauchamp: We give advice on a daily basis to ministers' offices.

Senator POLLEY: Things have been moving very slowly over the last four years, so I would have thought you could give us a broad outline of the sorts of things that you're looking at. You'd be well aware of the long waiting lists and the issues around the home care packages. I would have thought perhaps there was more work done that you could share with the committee.

Ms Rule: Ms Buffinton has just outlined a range of things that have happened to improve performance. We're operating within an existing system and an existing set of rules, and we are doing a lot of work and providing a lot of advice to government to maximise the performance of the system that we currently have. In parallel with that, there is an ongoing discussion with government about long-term policy reform options.

Senator POLLEY: Yes, but the ACAT contracts are going to run out in six months. That's not a very long time. In relation to making the adjustments and the changes that the sector would need and that the system would need to look at, I would have thought more work had been done. Are you far off putting your final submission to the minister?

Ms Buffinton: In terms of the integrated assessment, government has already outlined its intention to roll over the regional assessment service to 2020.

Senator POLLEY: Okay.

Ms Rule: Senator, we're conscious of the time frames but, as you can understand, we're not in a position to tell you today what the future direction is going to be. But we're obviously very aware of the time frames that we're operating within.

Senator POLLEY: But I'm not going to read about it tomorrow in the newspapers?

Ms Rule: I wouldn't have thought so.

Senator POLLEY: So you're still some time off. It's just that, when I've asked questions before and they say, 'It's not far away,' the very next day there's been an announcement. I wanted to gather—

CHAIR: Senator Polley, just for planning purposes—and obviously you'll take us through to the dinner break—can you give us a rough idea of how much you think you've got?

Senator POLLEY: Me?

CHAIR: Yes.

Senator POLLEY: In this outcome 1?

CHAIR: In Ageing.

Senator POLLEY: Oh, in Ageing? I've got at least another hour and a half.

CHAIR: Okay.

Senator POLLEY: Depending on how long the questions are, it could even go longer.

Senator DUNIAM: Your questions? Well, make them shorter, then!

Senator POLLEY: The answers. My questions will be short, but the answers are usually very long.

CHAIR: After the break, we will go to Senator Griff, Senator Siewert and then back to you, Senator Polley.

Senator POLLEY: Okay. Is there anyone that wants to ask something in 6.1 before I move on?

CHAIR: Sorry?

Senator POLLEY: Is there anyone else who has questions in 6.1? Otherwise I'm going to move on to 6.2.

Senator GRIFF: I have questions in 6.1. I think the chair indicated we could go—

Senator POLLEY: Backwards and forwards. As long as the department's happy with that.

CHAIR: Take us through to the break, Senator Polley.

Senator POLLEY: Sounds great. The long-awaited Home Care Packages Program data report was published a few weeks ago. Can you confirm that the report shows that almost 90,000 older Australians are waiting to access the home care package level that they've been approved for and that there are 35,154 older Australians receiving home care packages that don't meet their assessed needs? And is it accurate that 53,750 older Australians who have been assessed as being eligible to receive a home care package are not receiving a home care package, and, further, that 66,889 older Australians who have been assessed as being eligible to receive a level 3 or a level 4 package are not receiving either a level 3 or a level 4 package?

Ms Buffinton: That's correct.

Senator POLLEY: The government has announced it will convert lower level packages into an additional 6,000 packages at level 3 and 4 in 2017. Can you confirm that there is no additional funding associated with this commitment, and when will the 6,000 packages be delivered?

Ms Buffinton: I can confirm that there is no additional funding converting from level 1 and level 2 packages to the more highly demanded level 3 and level 4 packages. They are already rolling out, but it's not just in one instant. We are now increasing the offer of level 3 and level 4 packages and that will be going over the next few months.

Senator POLLEY: So how many have been released thus far?

Ms Buffinton: Of that 6,000? I probably will have to take that on notice. But the intention is to roll them out fairly quickly.

Senator POLLEY: How many of the level 1 and 2 packages will be scrapped to deliver the additional 6,000 level 3 and 4 packages?

Ms Buffinton: Just under 17,000—remembering, as you might recall, that a level 1 package is worth around about \$8,000 and a level 2 package is worth just under \$15,000, but a level 3 is worth almost \$33,000 and a level 4 is worth just under \$50,000 in terms of annual value.

Senator POLLEY: Will this create a problem in having access to that lower level package?

Ms Buffinton: In making that decision, the government did take into account that level 1 and level 2, when we offer those packages, are the highest volume of packages where people choose not to take them up. First of all, many who are offered level 1 and level 2 are already in Commonwealth home support. Whether they're a pensioner or they're independent, they do not pay for that Commonwealth home support. When they come into home care, if they're a pensioner, they do make a small contribution. If they're self-funded, they make a full contribution. At this point, consumers are opting to stay on their Commonwealth home support package and the relative attractiveness is when their needs get to a point of level 3 or level 4. So when we do offer them level 1 or level 2, they choose not to take up that package—not everyone, but on average there is a higher propensity not to take up level 1 and level 2 when they're offered.

Senator POLLEY: Have you got any data or statistics that you can provide to us on that?

Ms Buffinton: Yes, on notice. We can show how that trend works.

Senator POLLEY: Is this going to be the same situation going forward, where there's a merging of those two options?

Ms Rule: Do you mean of merging home care packages and Commonwealth home support?

Senator POLLEY: Yes.

Ms Rule: That decision hasn't been taken yet. You'll probably be aware that we've been consulting with the sector on options for reforming home care, but the government has not made a decision on integrating the two programs together.

Senator POLLEY: Has there been some work done on that?

Ms Rule: As I just said, you'd be aware that we've been consulting with the sector. The department issued a discussion paper. We sought consultation from the sector. We're currently looking at that consultation and using that to inform further advice on this matter.

CHAIR: We shall return at 7 pm continuing with outcome 6.

Proceedings suspended from 18:00 to 19:02

Aged Care Complaints Commissioner

CHAIR: Senator Griff, you have the call.

Senator GRIFF: Thank you, Chair. Aged Care Complaints Commissioner, if I could, please.

Senator SIEWERT: Can we all jump in on that after he has finished, or are we going to go back to where we were and get them to come back again?

CHAIR: We said we were going to move backwards and forwards between the items in aged care. I think we will let Senator Griff exhaust his questions, Senator Siewert, and then you can take us home.

Senator SIEWERT: Cool.

Senator GRIFF: 'Take us home.' That's a great line!

Senator SIEWERT: There are some things I won't do!

Senator GRIFF: Welcome, Ms Lamb. I'd like to refer to page 22 of your annual report where you state that you made 50 site visits, of which only seven were not announced. Why were only seven out of 50 not announced?

Ms Lamb: Our site visits are a little different from the ones the accreditation agency does. Our site visits are usually part of the process of dealing with a complaint. Most of the time when we make a site visit it's usually to talk to the care recipient and often to meet with the family, or it may be to interview particular staff, so they kind of need to know we're coming. It's a little different from the role of the agency, which I'm sure Nick will talk about, where they're doing visits as part of their assessment and monitoring.

Senator GRIFF: Were the unannounced ones done for a particular reason, such as there was a concern of some type?

Ms Lamb: It depends on the complaint issue. When we receive a complaint we look closely at the issue, and, on occasion, there is an issue which is such that we think that the best thing to do is to go straightaway and have a look.

Senator GRIFF: What were these seven?

Ms Lamb: I'm sorry; I don't have that information at hand. Obviously with 4,500 complaints—

Senator GRIFF: I understand.

Ms Lamb: I could certainly take it on notice.

Senator GRIFF: That would be great. In the *Oakden report*, the chief psychiatrist noted that Oakden management:

... became better at knowing how to produce documents and records that Accrediting Bodies and Surveyors wanted to and expected to see; and better at ensuring staff knew what to say.

In other words, they were better at putting up a good front than running a good facility. What do announced visits achieve that unannounced visits do not?

Ms Lamb: It depends. If you're talking about a complaints context, I'll go back to my previous answer, which was: it's about the nature of the issue and the concern that has been raised and whether there is a need for us, without anyone knowing we're coming, to go in and have a quick look.

Senator GRIFF: So, whenever there is an issue, you would make that an unannounced visit?

Ms Lamb: Yes. An example might be where something happens at a certain hour of the day and the only way, really, to find out whether that is in fact happening is for us to just turn up and have a look.

Senator GRIFF: On page 24 of your report you mention that 511 complaints were referred to external agencies. Do you leave it at that, or do you follow up with the particular agency or the complainant about the outcome?

Ms Lamb: We follow up certainly with the department and the quality agency, who are the main people that you will see that we refer to. With some of the other agencies we have letters of understanding, and people like the coroners and AHPRA and so forth will generally, at some point, let us know what they've done.

Senator GRIFF: The 468 complaints to the Aged Care Quality Agency were mainly over wound and medication management, staff numbers and resident hygiene. How serious were some of these complaints? Were they significant?

Ms Lamb: It depends. The level of seriousness is usually reflected in the type of referral. You'll see in the report that we do three different types of referrals. In the most serious cases we do a type 3 referral—I make the decision that it needs some quite urgent attention by the agency. The way it works is that we take the view that the agency is best placed to take any urgent action, in terms of their powers and our powers and roles, while we go on and resolve the complaint.

Senator GRIFF: How do you measure that a complaint has been dealt with satisfactorily?

Ms Lamb: We measure what we do with the complaint. We certainly don't have any role in terms of determining whether what the agency has done is satisfactory.

Senator GRIFF: My office was recently contacted by the family of an age pensioner who was placed in a nursing home, and, because he had no assets, the nursing home asked his family to provide a guarantee for him against their own property. When my office contacted the provider, they acknowledged that they were in the wrong. Is this widespread? Is this a common complaint?

Ms Lamb: I obviously can't comment on that one; I'm not aware of it in particular. But we are seeing complaints from people around fees and charges, both in residential care and in home care, and it is an area where we have found concerns in terms of issues as to whether or not services are charging for things that they shouldn't be charging for.

Senator GRIFF: Would you consider undertaking any education to inform aged-care residents and their families on their rights in this area?

Ms Lamb: We do do education and increasingly we're trying to focus on consumers to find ways to let them know their rights. We use the charter of residents' rights and also the home care recipients' rights in our work in assessing whether or not a provider has met their responsibilities. We certainly look at those rights and regard them as responsibilities that need to be met.

Senator GRIFF: Have you ever sanctioned any aged-care provider for asking for a guarantee?

Ms Lamb: I don't have the power to sanction.

Senator GRIFF: I know Senator Polley is desperate to jump in on some of those, I'm sure; but I'll move through what I have here as quickly as possible. Thank you, Ms Lamb.

Australian Aged Care Quality Agency

Senator GRIFF: AACQA has obviously had a hard look at its processes this year.

Mr Ryan: Yes.

Senator GRIFF: How many other homes have you uncovered this year that, like Makk and McLeay, have been generously treated by auditors—that is, they did not deserve a clean slate and three-year accreditation?

Mr Ryan: We've undertaken our normal range of visits this year. We treat every visit on a risk basis, based on existing information and based, perhaps, on any referrals from the department or from the Aged Care Complaints Commissioner, as you've just heard. We are rigorous in undertaking all of our visits. We certainly are aware and have been deeply focused upon what happened at Oakden—at the Makk and McLeay wings of Oakden. I've sought some independent advice, and we've fully participated in the government's Carnell-Paterson review to ensure that the government has options going forward for strengthening our regulatory framework.

Senator GRIFF: How many other homes have you identified?

Mr Ryan: Are you talking about homes where we've identified serious risk?

Senator GRIFF: Yes.

Mr Ryan: Or homes where we've—

Senator GRIFF: Both.

Mr Ryan: If I can have one moment. To date this year, we've undertaken 204 reaccreditation audits and we've undertaken 15 review audits. Of those 15, we've found in 14 of those that they had unmet outcomes, and we have called serious risk a number of times this year. And so, just under our system, where we do believe that there are issues with a home, we will undertake a full review audit. That's against all 44 expected outcomes.

In the event that we find that there is failure against the outcomes—failure by the provider against those outcomes—we then test to see whether one or more identified care recipients would place that risk to their health, safety and wellbeing. Where we believe that's the case, we will reach a decision called 'serious risk' under section 2.63 of our principles. On that basis we would refer to the department, to the secretary or her delegate that we have found serious risk, and they will consider it as a basis for a finding of immediate and severe risk, and if so, that could result in a sanction. We found 11 cases of serious risk in the financial year to date.

Senator GRIFF: Is that 11 out of the 14, or is that separate?

Mr Ryan: I beg your pardon, no; that's 11 findings overall, against all accreditation visits, which includes—year to date—696 unannounced assessment contacts, 88 announced assessment contacts, 15 review audits and 204 reaccreditation side audits.

Senator GRIFF: Could you provide that list, or those details?

Mr Ryan: Of course, we will be happy to table that, Senator.

Senator GRIFF: Thank you. I note in the information you provided on notice to myself and Senator Polley that some homes look to have suspiciously similar traits to the Makk and McCleay Nursing Home. For instance, Martindale Nursing Home in SA has passed with flying colours since 2008, with three-year accreditation at each audit; most recently, in fact, in February this year. Then three months later, in May, it failed to meet 30 outcomes and its accreditation was revoked. What happened there? Did something change dramatically, or would it be very lax auditing?

Mr Ryan: No; that's a good question, Senator, thank you. In the case of Martindale, our audit in February of this year passed all 44 outcomes. By means of context though, in the process of a significant physical refurbishment—they were building a new facility and they were ill-prepared for the new built environment—not only did they have additional residents that came in, they also had a less consistent staffing model and were often reliant upon agency staff, and it was a physically much bigger facility than the facility that we audited in February. On that basis, to have significantly more residents come in with higher acuity, with a less consistent staffing model, we found serious risk and we did ultimately take a decision to revoke accreditation, which we did on 26 May this year. I should also mention that Martindale—that is, the approved provider—has applied for a review of our decision before the AAT, and so we are of course waiting for the outcome of that. We did find extensive non-compliance in a review audit from 8 to 18 May this year. It found extensive non-compliance, and it was on that basis that we reduced accreditation and, in fact, revoked accreditation. The department also imposed sanctions for a period of six months. But if our revocation decision stands before the AAT that would result in no more accreditation for that facility.

Senator GRIFF: So the last positive audit was actually in February, then obviously everything has changed. Is there any reason why the 2017 audit report is not available on your website? When you click on the link, you get the May 2017 audit report, even though it actually says it's the February 2017 report.

Mr Ryan: I would have to check on that, but normally the most recent decision that has a bearing on a period of accreditation is on our website. If you seek that February report, we will be happy to table that or to provide that to you. I would need to come back with a specific reason as to why the February wouldn't be available, but we will certainly follow up on that.

Senator GRIFF: Thank you. In a question on notice at the last estimates, I asked to obtain copies of the care recipient and staff surveys used during the Aged Care Quality Agency's recent audits at a nursing home, and the response was that the Aged Care Quality Agency does not routinely retain documents viewed during an assessment of a home and can confirm that they do not have copies of the surveys. Why don't you keep copies of the surveys? I find it unusual that you've undertaken that work but there is no physical—

Mr Ryan: We have a policy where there is a range of information available, and I would need to go back and review the specific reasons as to why we wouldn't provide that, but clearly our aim at present and the work that we've undertaken this year is to undertake a consistent consumer experience survey with between 10 and 15 per cent of the residents of a home or their family representatives. That information has been made available for every decision made since 1 July. It has been developed by the Lincoln Centre for Research on Ageing at La Trobe University. It provides a much greater transparency to existing residents and intending residents about what the actual experience was of residents within that home. On the technical question of the provision of those surveys, I would have to take that on notice, but the intent—and it's very clear—is to be far more transparent for consumers. We do provide that information in a way we've not done before.

In closing, in the past there was not a consistent set of questions asked, but we have brought a greater consistency, a greater transparency and certainly greater information to consumers, and we gather it in a way that more specifically informs the work of our surveyors on site.

CHAIR: Senator, that is 15 minutes. Please keep going, but can we—

Senator GRIFF: Five and I will cover it, Chair.

CHAIR: That's fine.

Senator GRIFF: I'd now like to ask some questions about the home-care packages and would like to refer back to a question on notice from the last budget estimates. The question referred to what happens when a person receiving a home care package passes away or moves from a home to an aged-care facility. The department advised that noncompliance is identified through a range of resources, including complaints raised with the Aged Care Complaints Commissioner. Can you advise what the range of sources is to verify unspent funds are actually returned?

Ms Buffinton: The obligation is on the provider to communicate with both the Commonwealth and the family if somebody is moving to residential care, has passed away or has decided to withdraw, so the onus is on the provider to communicate and give a detailed account within 56 days of somebody leaving. As we said in our reply, within 14 days they must return to the consumer's estate the consumer's portion. Within 70 days of ceasing care they have to return the Commonwealth's portion. They do have to give an itemised list within 56 days of the care ceasing, and they have those responsibilities. If they don't undertake those, we can undertake regulatory action on the provider.

Senator GRIFF: How do you verify that someone has passed away? Do you verify it yourself or do you wait for the provider to come back to you and say, 'This person is no longer with us'?

Ms Buffinton: Certainly the obligation of an approved provider under the Aged Care Act is to enter into the Department of Human Services system that somebody has left care for whatever reason or gone into residential care.

Senator GRIFF: So you don't look at any births and deaths records or—

Ms Buffinton: We also in the background are doing checks. The Department of Human Services does have data matching in the background that is constantly checking.

Senator GRIFF: So you are able to identify if someone has passed away?

Ms Buffinton: Yes.

Senator GRIFF: But how do you know that the provider is actually returning appropriate funds to you? And do you do regular audits? Do you undertake audits of the providers to make sure that they are returning the correct amount of funds?

Ms Goddard: As Ms Buffinton said in relation to unspent funds, there is a process that we go through through the department and through the service provider, and that is led by the service provider.

Senator GRIFF: Do you audit the providers?

Ms Goddard: I would need to take that on notice.

Senator GRIFF: So you don't believe that you audit the providers?

Ms Buffinton: This will link in with the Department of Human Services. The Department of Human Services run the payments to the provider. They actually have the system of identifying that somebody has left and so therefore we cease payments, so I would have it take that on notice because that would be an answer that we would provide in consultation with the Department of Human Services.

Senator GRIFF: It's a pretty important answer, I think, because there's a lot of money involved there. I'm aware of instances where, I believe, the provider has actually retained funds, so I'm very interested in your response to that one.

Ms Rule: I think it's important to note two things. One is that the officer didn't say we don't conduct audits; we just need to take that on notice. The second thing is to note that, as the Department of Human Services is responsible for the payments that go in and out from the Commonwealth to providers, we are going to need to check with them.

Senator GRIFF: Okay. How does the department ascertain that the provider is appropriately charging for legitimately provided services and not necessarily using up a package prior to a person passing away? Is there any mechanism in place to check that?

Ms Buffinton: First of all, now that we've entered into a marketplace in February, with consumer direction we are doing a lot of work to inform consumers. We send letters out giving them information about packages and what they should expect. We've gone to a lot of trouble to outline to providers what is expected of them as an approved provider. We also encourage consumers, if they are and happy with fees—

Senator GRIFF: That's fine, Ms Buffinton, but I'm talking about someone who has passed away, so they're probably not that unhappy at that particular point, because they're not aware of what is still remaining there. If you could provide on notice again the auditing and also whether there are random spot checks or follow-ups generally, not necessarily for people that have passed away, I think we'd appreciate that.

Ms Rule: Just to be clear: if a person has died, the provider should no longer be providing services.

Senator GRIFF: But there's a credit that that provider will have. That is your money, as well as funds for the family.

Ms Rule: Ms Buffinton has outlined the circumstances and the time frames in which providers have to return that money to the Commonwealth. If they're not doing that and they're continuing to purport to provide services to a consumer that's no longer accessing them then they're in breach of all of their obligations.

Senator GRIFF: My question relates to whether you are auditing to make sure they are doing the right thing.

Ms Rule: We are aware when somebody has passed away, and therefore we're aware of when services should have ceased and when balances should have been returned. If providers are not meeting those obligations then the service will pick that up, and that's through services provided by DHS.

CHAIR: Senator Siewert, you have the call.

Senator SIEWERT: I have a number of areas I want to go through, so I will try to move through them as quickly as I can. I wanted to go to the homelessness supplement. You may need to take some of these questions on notice. I'm after, initially, how many places in how many services were or are receiving the homelessness supplement for residential care and also the viability supplement for people who are homeless or at risk of homelessness. Is that something you can supply fairly easily?

Mr Murray: Unfortunately, we don't have those details with us. I'm happy to take that on notice.

Senator SIEWERT: In that case, can you also take on notice how much was spent on the homelessness supplement for residential care and the viability supplement for those who are homeless and/or at risk of homelessness?

Mr Murray: Yes.

Senator SIEWERT: Is there a reason why you don't have it?

Mr Murray: We don't have the detailed numbers you have. I can find the details and the broad numbers of the homelessness supplement and viability supplement for you.

Senator SIEWERT: Sorry, the—

Mr Murray: For the first question, you asked about it in terms of the more detailed breakdown. I don't have those details available in terms of numbers. But, in terms of the aggregate amounts of money that we spend on the homelessness supplement and the viability supplement, I will be able to find those for you and give them to you shortly.

Senator SIEWERT: That would be good—thank you.

Mr Murray: For the homelessness supplement, the expenditure is approximately \$8 million. The veterans' supplement is approximately \$2.8 million.

Senator SIEWERT: Was that for 2016-17?

Mr Murray: Yes.

Senator SIEWERT: Sorry, can you say that again?

Mr Murray: For the veterans, it's \$2.8 million, and for the homeless it's \$7.9 million.

Ms Rule: Senator, did you ask about the viability supplement?

Senator SIEWERT: Yes.

Mr Murray: The viability supplement is \$44.6 million.

Senator SIEWERT: For the homelessness or those at risk of homelessness?

Mr Murray: The viability supplement covers a number of components. It covers rural and remote areas. There's also a homelessness component of that.

Senator SIEWERT: Can you break it down to the homeless—

Mr Murray: To get that breakdown, I would have to actually take that part on notice.

Senator SIEWERT: Okay. That's why I was asking—

Mr Murray: Trying to break that down into its components?

Senator SIEWERT: Exactly. Can you take that on notice? If you can break it down to each of the components, that would be really appreciated.

Mr Murray: Sure.

Senator SIEWERT: Can you tell me how much was budgeted for that amount—for both of those?

Mr Murray: For the viability supplement?

Senator SIEWERT: And the homelessness supplement.

Mr Murray: I'm just double checking my figures here. For the viability supplement, the estimate was \$44.6 million, and the payment was about \$43 million, so slightly under the estimate. The homelessness—was that the other one you were after?

Senator SIEWERT: Yes, please.

Mr Murray: The estimate was about \$7.9 million, and it came out at about \$8.2 million.

Senator SIEWERT: Thank you for taking those on notice. I've had it put to me that the—and I spoke about it in the Senate not that long ago—value of the homelessness supplement is decreasing relative to increasing costs. Have you done any work looking at whether that is in fact correct and whether the amount of the supplement is actually still allowing people to provide a sustainable service?

Mr Murray: So, in terms of the homelessness supplement—

Senator SIEWERT: I'm particularly interested in the homelessness supplement with that question.

Mr Murray: Yes. I don't have detailed information on that, but, generally speaking, people getting the homelessness supplement, for example, have ACFI scores that are below the average ACFI scores. That often reflects the fact that the needs of that group are somewhat different in terms of the people with complex, high-level health needs coming in. Nevertheless, their funding has been growing. Actually, their funding relative to the broader ACFI fund, and that gap between them, has actually been closing because they do get the additional homelessness supplement and part of the viability supplements to help that funding. So, from our perspective, the funding is continuing to grow. Compared to the general ACFI growth, that gap between them has actually been narrowing over the past couple of years rather than expanding.

Senator SIEWERT: Thank you. I'll send you some further questions on notice, because they're quite detailed, around some arguments that argue very differently to the point that you've just made. So I'll ask that you take it on notice and have a look at it for me.

Mr Murray: Yes, I'm happy to do that.

Senator SIEWERT: Thank you. That's appreciated. Can I go to the ACFI flexi and the recent report from the ANAO that was released last week? Are you aware of that report?

Ms Rule: An ANAO report into what, sorry?

Senator SIEWERT: Aboriginal aged care.

Ms Rule: So it's not last week. I think you will find that the ANAO audit of Indigenous aged care was several months ago.

Senator SIEWERT: Sorry, it was.

Ms Rule: That's okay.

Senator SIEWERT: I am confusing my reports—sorry.

Ms Rule: I was thinking that maybe I had missed an audit report.

Senator SIEWERT: Let me just find it. There are lots of reports here. Yes, here we go. You've obviously had a chance to look at it?

Ms Rule: Yes.

Senator SIEWERT: In terms of the recommendations, the question I really want to focus on is the ACFI flexi fund recommendation No. 1—providing an opportunity for eligible, existing, Indigenous-focused aged care services—that is not currently funded under the program to access the available funding under this scheme. The department agreed, with qualification. Can I ask you to expand a little on your thinking on that and where it's progressed to?

Ms Rule: Senator, you'll have to forgive me. As that audit report was released before the previous estimates, I don't have a copy of the recommendations and the response in front of me. I can tell you that our thinking on agreeing to that recommendation, with qualification, is that, yes, we should look at opportunities to expand that program but that we really had to do that within existing resources or take it through a budget process to get additional resources. So the qualification was about how we would manage within the existing funding envelope. Since then we have provided opportunity for providers. We have offered some expanded funding for those services, so we have partly implemented that recommendation.

Senator SIEWERT: So how much have you—

Ms Rule: I'm sorry, I'll have to take that on notice as I don't have a brief on that.

Senator SIEWERT: Could you take on notice whether that has been taken up?

Ms Rule: Yes.

Senator SIEWERT: You're saying it has been?

Ms Rule: We basically did a funding round where providers could apply for additional funding, so all of the available additional funding was allocated through that round. I just can't tell you the numbers off the top of my head.

Senator SIEWERT: If you could take that on notice.

Ms Rule: Yes, certainly.

Senator SIEWERT: You said you partly fulfilled that?

Ms Rule: The recommendation basically says that you should open up the market.

Senator SIEWERT: Yes.

Ms Rule: Our qualification was that, actually, within the existing envelope, we are not able to open up the market.

Senator SIEWERT: Yes.

Ms Rule: So we expanded within the existing resources, but we were not able to go to the full—

Senator SIEWERT: You had to go back for some more funding?

Ms Rule: Yes.

Senator SIEWERT: So is that still under active consideration?

Ms Rule: Yes.

Senator SIEWERT: I raised this at our last hearing because it had come out of our aged-care workforce inquiry. It is the issue around home care packages, particularly in remote locations, where providers were finding that the current form of CDC wasn't culturally appropriate, and, even if it was, they were finding it difficult to get providers. Have you done any further work looking at CDC and its provision in remote communities?

Ms Rule: Yes. There are a couple of threads to this.

Senator SIEWERT: Yes.

Ms Rule: The first is to note that, since the changes were implemented on 27 February, there are at least two providers of home care packages in every aged-care planning region. So we know that, even in remote areas, there are at least two providers active in those areas. We are constantly working with providers to make sure that they are providing culturally appropriate services. The minister has announced a range of work on diversity strategies and we're working closely with the Indigenous, health and other sectors to make sure that we're improving the services in those areas. In parallel, the Tune review talks about looking into Indigenous, rural and remote service delivery. In that review, if we're moving to a market based system, what provisions do you have in place to protect those areas where the market is thin or non-existent? We are doing some work on advising government on a response to that review that would help to improve some of the options available in remote and rural areas.

Senator SIEWERT: What's your time line for that?

Ms Rule: In coming months I think government will make some decisions on the broader implementation of the Tune review.

Senator SIEWERT: This year? You say 'in coming months', but there are only a couple of months left.

Ms Rule: Some of it will be tied up in budget processes, I expect.

Senator SIEWERT: Yes.

Ms Rule: So that's probably the likely time frame.

Senator SIEWERT: I understand the focus that you've taken in terms of markets. But a lot of the comment that was made to us was that whether there's a market or not, it's not working. Also it's not appropriate for the particular circumstances in remote communities—I mean culturally. There's a provision of services in a culturally appropriate manner. But I think we had a conversation previously in terms the individual people getting an individual package and immediately wanting to share it with the community. Is that also being taken into consideration in your thinking?

Ms Rule: Yes. We're looking for opportunities to change the policy, or provide advice and options to government about making sure that the programs that we deliver are fit for purpose for all consumers, noting that we're aware of some of those issues that exist both for Indigenous people and in remote areas.

Senator SIEWERT: Yes. And even in some regional areas?

Ms Rule: Yes.

Senator SIEWERT: And that is part of that work as well?

Ms Rule: Absolutely.

Senator SIEWERT: In terms of having at least two providers in each area, how frequently are some of those changing over in some of the regional and remote areas?

Ms Rule: I'd have to take that on notice. I'm not aware.

Senator SIEWERT: I'm particularly interested because, again, it's anecdotal. I know of one where this has happened—where one of the providers has packed up and left. So in those regional and remote areas, again, it's a market issue.

Ms Rule: Yes.

Senator SIEWERT: Could you perhaps take on notice how frequently some of those providers are in fact non-existent?

Ms Rule: Yes. We also know that there's been a real spike in providers coming into the market since the new policy arrangements have been in place. So we'll have a look for you at what data we've got about that churn of people coming in and out.

Senator SIEWERT: That would be appreciated. Can I go to the Carnell report? I've got to say, I was supposed to have a briefing this afternoon, but because of estimates I didn't. That was my fault. I didn't get it. I have one now on deck for tomorrow. There's a number of recommendations.

Senator POLLEY: But there's only one that government has taken up.

Senator SIEWERT: That's where I want to go. What's the process for the other recommendations?

Ms Rule: The report was only released, as you know, yesterday.

Senator SIEWERT: Yes, I'm aware of that.

Ms Rule: The next steps for us are to look into all of those recommendations in detail, to look at implementation arrangements and costs. A large number of them have legislative change attached to them. We will start in earnest next week the process of examining each of those recommendations and providing detailed advice back to government about how we can go about the implementation of them.

Senator SIEWERT: Do you have a time frame for that?

Ms Rule: Again, I would expect that that's probably in the budget context, because some of them will have resource implications and, as I said, legislative implications as well.

Senator POLLEY: Can I just follow up on that? The one recommendation the government has said it will implement—what's the time frame? That's legislative.

Senator SIEWERT: That's exactly where I was going next.

Senator POLLEY: You go, then.

Senator SIEWERT: No, go on. That's where I was going.

Ms Rule: The minister has said as soon as possible. Our initial analysis is that we don't actually require legislative change for that recommendation to be implemented, that we can do that through changes to the principles. So we actually can do that without legislative change, is our analysis. That's been our advice to government.

Senator POLLEY: What about the cost?

Ms Rule: Again, we believe we can do it within existing resources.

Senator POLLEY: What's the cost going to be to the providers?

Ms Rule: Again, within existing resources. But the providers will not be paying any more to move to the unannounced visits the minister announced yesterday.

Senator SIEWERT: If they were doing the right thing all the time—

Senator POLLEY: But how many times are they going to have to pay that? If you're in a regional provider and you have—

Ms Rule: Perhaps I can just walk you through what the minister announced yesterday. The recommendation in Carnell talks about accreditation visits and reaccreditation visits. Currently accreditation visits and reaccreditation visits are announced. What we are now going to move to is that those reaccreditation visits will become unannounced. Providers already pay for the accreditation scheme, so they shouldn't be paying any more. All that's going to happen in this context is that we won't be telling them when we're coming to do that reaccreditation visit.

Senator POLLEY: But the providers challenge the fact that what they're paying now is too much. So would there be any modelling done as to whether or not that is a fair cost?

Ms Rule: We'll be working within the existing regime, which is that the charges are clearly laid out for providers for accreditation. Those charges will not be going up. The charges won't go up.

Senator POLLEY: They won't be going down either.

Ms Rule: No. The charges will be what they currently are.

Mr Ryan: If I might make a comment, there was a move to full cost recovery of reaccreditation audits which are currently announced, but the minister indicated the government's decision yesterday. So there's full transparency around the reaccreditation cost. That's all costed. It's publicly available according to Department of Finance guidelines. And certainly new innovations that we have introduced, including the CAT device and the CAT technology—the computer assisted audit tool—which is currently being used everywhere will

lessen any pressures on cost increases, because the price of writing a site audit draft report is significantly reduced.

Senator SIEWERT: Have any of the providers recently raised with you their concern about the costs of the audit process?

Ms Rule: Not that I'm aware of.

Mr Ryan: I might mention that there was a cost recovery implementation strategy when we did the cost recovery for reaccreditation audits. And we have engaged with the sector around a levy for unannounced assessment contacts—the so-called announced visits—and there is a range of different types of visits that go with that. Government is considering proceeding forward on that. There was significant feedback from the sector on cost recovery for those charges. If you give me a moment I can give you some more information.

Senator SIEWERT: Okay. That would be appreciated. But this has been over a period of time?

Mr Ryan: That's correct.

Ms Rule: But, again, let me just be clear that that's not what the minister announced yesterday. He announced reaccreditation visits, which are not the subject of that cost recovery implementation statement that Mr Ryan's talking about. They are separate things.

Senator SIEWERT: Yes, I understood that. That's another process.

Ms Rule: Yes. That's right.

Senator SIEWERT: That's correct, isn't it?

Mr Ryan: Correct.

Ms Rule: Which is not legislated yet, and the legislation hasn't been introduced. Until such time as that legislation is introduced then we work under the existing regime and the existing fees and charges.

Senator SIEWERT: So, that—and I'll come back in a second—process, the other unannounced visits, was announced a while ago wasn't it?

Mr Ryan: Correct, yes.

Senator SIEWERT: That requires legislative basis but the reaccreditation process doesn't.

Ms Rule: That's right.

Mr Ryan: Correct. And just for further information—

Senator SIEWERT: It's going to be massively confusing when it actually does hit.

Ms Rule: It's very technical.

Mr Ryan: Yes. On consultation with the sector around the proposed unannounced levy, we received 26 submissions. There was a range of points of view around cost impacts on the sector generally. All of that information has been provided to government and has informed government's decision to proceed in due course with the introduction of a bill towards that levy. It is important to just clarify that there are no projected additional charges attached to a move to having unannounced reaccreditation audits. It should cost no more whatsoever to move to an unannounced reaccreditation audit. It's just a matter of whether we give notice to a

provider that we're coming to do it. We are working with government as to how that might be implemented but we can emphasise that there's no projected cost impact.

Senator SIEWERT: I think the point Senator Polley was making is that some providers are concerned about the cost they are currently carrying for the reaccreditation process.

Mr Ryan: I am aware that there are a range of views in the sector around that. It is an established cost, and the move to cost recovery made that far more transparent around reaccreditation audits. But I'm certain that there are a range of views out there.

Senator SIEWERT: Perhaps you can remind me—because, I must say, the years mix into each other sometimes with these measures—when the cost recovery of accreditation was brought in.

Ms Laffan: That was announced in the 2015-16 budget.

Senator SIEWERT: So, really, to be fair to the providers, it's really only now starting to wash through the system, in terms of those costs.

Ms Laffan: Sorry—with respect to accreditation? Or the unannounced visits?

Senator SIEWERT: The reaccreditation process.

Ms Laffan: The 2015-16 budget announcement was with respect to full cost recovery—

Senator SIEWERT: Yes, that's what I meant.

Ms Laffan: prior to that period when visits were still cost recovered.

Senator SIEWERT: Yes.

Ms Buffinton: And the full cost recovery for accreditation services came in from 19 May this year. There are also safeguards, which I think we may have discussed earlier, that homes with fewer than 25 places are given a 50 per cent reduction in cost recovery, homes that attract the viability supplement also receive a 50 per cent reduction in cost recovery and homes that have fewer than 25 places and receive the viability supplement do not pay anything under the new cost recovery arrangements.

Senator SIEWERT: Thank you. We've just been looking at the safety and quality safeguards NDIS framework, where many of us are very engaged with the restrictive practices process. Is thought being given to standardising an approach across there?

Ms Rule: Not at this stage. That doesn't mean that we're not talking to each other, because we are. But I think there's also recognition that they're different systems providing different services in different contexts.

Senator SIEWERT: Yes, I understand that, but it's still restrictive practices, which we're trying to move away from.

Ms Rule: Yes.

Senator SIEWERT: So, you're talking to each other, but there's—

Ms Rule: As we move into the detailed implementation planning of the response to this review, I would expect that talking to our colleagues in NDIS is one of the things we'll need to do as part of that.

Senator SIEWERT: Okay. I might follow that up as you start rolling out some of these other measures.

Ms Rule: Certainly.

Senator SIEWERT: I just want to slip back very quickly to the unannounced visits. Can you step us through the timetable? There is no extra cost. There's not a legislative requirement. Can you just step us through then when you want to have them actually start by?

Ms Rule: I can't answer that question yet. We're still working through that. One of the things the minister has asked us to do is to consult with the sector about how much time we need to implement that. Obviously we have some detailed work to do about how we implement it. The minister has asked us to do it as soon as possible, but we haven't committed to a time frame as yet.

Senator SIEWERT: There is no ballpark figure of, 'We want it done by the end of next year,' or sooner.

Ms Rule: I'd anticipate earlier than that.

Senator SIEWERT: Yes. I was going out as far as I thought that people might want you to move it and then see if we can move in—so, mid-next year.

Ms Rule: At the latest, but I would anticipate earlier than that.

Senator SIEWERT: When does the consultation start?

Ms Rule: That's a good question. I've already spoken to a number of the peak sector bodies today, as you can imagine.

Senator SIEWERT: I suspect that's not formal consultation.

Ms Rule: No. Again, I can't answer that question.

Senator SIEWERT: This year?

Ms Rule: Yes.

Senator SIEWERT: So the proposal is you do the consultation this year.

Ms Rule: Yes.

Senator SIEWERT: Will it be finish it this year?

Ms Rule: I would hope so.

Senator SIEWERT: How about I ask a couple more questions and then hand over to Senator Polley, on the condition that I can ask a couple more later?

CHAIR: Yes—a couple more.

Senator SIEWERT: I do have a long list. Can I ask for an update on where you're at with the workforce inquiry report itself?

Ms Rule: Yes, sure. Do you mean the response to the Senate inquiry?

Senator SIEWERT: Yes. Sorry, I wasn't clear.

Ms Rule: No, that's okay.

Senator SIEWERT: It is day 4 at nearly 8 pm!

Ms Rule: That's fine. We are currently working with the government to do a formal response to the report. That'll go through all the normal processes it has to go through to get government approval, and the government will table that at the appropriate time. Having said that, we're starting the work. As you'll be aware, the minister has already announced the chair

of the workforce task force. Shortly, I expect that government will announce the terms of reference of that task force, which will take into consideration the recommendations that the Senate inquiry made. He'll also announce the full membership of that task force.

Senator POLLEY: Is that going to include consumers and whether or not there are going to be any union representatives?

Ms Rule: That's a matter for the minister. I can't pre-empt the minister's announcement.

Senator POLLEY: You haven't done any suggestions.

Ms Rule: We certainly have provided plenty of advice to government on the make-up of that task force, and that's a matter for the minister to announce when he chooses.

Senator SIEWERT: Does it include consumer representatives and workforce representatives?

Ms Rule: That's a matter for the minister.

Senator POLLEY: Minister Nash might be able to help you.

Senator Nash: You can ask.

Senator SIEWERT: Can you tell us whether the advice given to Minister Wyatt included members of consumers and representatives of the workforce?

Senator Nash: I would have to take that on notice for the minister.

Senator SIEWERT: Could you take that on notice, please?

Senator Nash: I'm happy to.

Senator SIEWERT: Thank you. In terms of 'announced shortly', is there a time frame for that?

Ms Rule: It's very soon.

Senator SIEWERT: Before the end of the year?

Ms Rule: Yes, before the end of the year.

Senator SIEWERT: Next week?

Ms Rule: It's up to the minister when he chooses to announce that, but I expect it will happen soon.

Senator SIEWERT: What about the week after or the week beginning the 30th? We're all getting a bit stir-crazy! I understand that you're working on the response—that you're already starting to implement or work on some of the recommendations. In terms of minimum staffing hours, in particular nursing ratios—let's start with 24/7—where are you at with those sorts of considerations? Is that being dealt with as part of the task force or are you dealing with that matter separately?

Ms Rule: I think the answer to that is probably: both. It certainly will be referred to the task force for consideration but, as you probably aware, it's also tied up already in some of the quality standards which refer to staffing. Consideration of the single quality framework and those sorts of things has to reference that as well. It's been considered on a number of fronts.

Senator SIEWERT: Is something likely to come out the other side of that consideration?

Ms Rule: I can't answer that question. I don't know.

Senator SIEWERT: Is it, again, a matter of a more short term—I'm going for short-term time frames than medium- and longer-term time frames. Is it something that's going to be resolved fairly quickly, or do you anticipate it's still a longer conversation?

Ms Rule: It's a longer conversation. It obviously has significant resourcing implications for providers as well as the obvious workforce implications. I suspect it's a longer-term conversation than short.

Senator SIEWERT: Will that also include some of the issues around 'renumeration'? I got in trouble from a member of the public because I didn't say that correctly earlier in the day. 'Renumeration'—is that the right word?

Ms Rule: No. It is remuneration, but I know what you mean.

Senator SIEWERT: Yes, that one. Will that include those issues as well, given that there has been significant comment about the reduced wages that nurses in aged care get, for example?

Ms Rule: It's not the role of the Commonwealth to set that. It's a matter for the employers as to how much they're paid.

Senator SIEWERT: Yes. I understand that, but that's also then related to how much they get—

Ms Rule: I would expect that those kinds of issues get considered in the context of the workforce strategy. A key issue for that task force is going to be: how do you attract and retain the right kinds of people to get the right kind of mix of workers into aged care? And, obviously, how you remunerate those people is part of that consideration.

Senator SIEWERT: Thank you. I'll leave it there.

Senator POLLEY: I have a few more questions here. The department and the minister have had the Tune report for some considerable time. In relation to the waiting times for home care packages and the future needs of consumers and that assessment, has there been any modelling done or any data collected as to why this is happening? There seems to be a lag time from when people are still being assessed to getting their home care package. I know you said earlier that those figures have come down, but we're still hearing reports that that's contrary to what your evidence has been today.

Ms Rule: You've seen the report on the data about the wait times and the queues for home care packages. For the first time, that data's been published. We've been through the numbers with you. We've talked about the fact that government's decided to tip an extra 6,000 packages into where the highest demand is. You're aware that the Tune report talks about some of the bigger picture, long-term sustainability issues for the system and that we have to consider those in the context of the government's response to that Tune review.

Senator POLLEY: Yes, but you've actually had the report for some time. The minister's had the report for some time. You must have done some modelling. The providers have been waiting for some reform for some time, and I'm sure you're well aware of providers who are concerned with the cuts that have been made. They've been calling for more reform, and yet we haven't seen any action. You're saying that you're working, and it's up to the government and the minister of the day to make those announcements. It's not going to be very satisfying to the providers.

Ms Rule: Many of the recommendations in the Tune review have significant resource implications, and those need to be considered within the budget context. They also have legislative implications that need to be considered. We need to work through the appropriate processes to give advice to government and for government to make those decisions.

Senator POLLEY: Maybe you can answer this one for me: how do you propose to achieve and fund the 2021-22 target of 45 packages per thousand people aged 70 when they are converting so many low-level packages into high-level packages?

Ms Rule: We've only converted 6,000 packages to higher-level packages. That doesn't have a significant impact on the ratio by the time we get to 2020. That's an immediate measure to relieve some of the pressure, but there are those issues about the ratio. What decisions get made and how they affect the ratio will form part of our advice to government.

Senator POLLEY: So the temporary reallocation of unused residential places, assuming this continues to fall, would that play a role?

Ms Rule: Sorry, I'm not quite sure I understand your question.

Mr Culhane: The recommendation that you're referring to from the Tune review is one of the recommendations before government for consideration. You've asked the question: will that form part of the answer? The answer to that is: it may. It depends on government's consideration of the Tune review recommendations.

Senator POLLEY: Recommendation 27 of the Tune review calls on the government to integrate the RAS and the ACAT assessment, which we've talked about before. The recommendations are in line with the Aged Care Roadmap. What's the time frame for the government to respond to that, bearing in mind that my understanding is providers have been lobbying for this for some time, and they're looking for, as I said before, some reform, which has become quite stagnant? Can you shed any more light on the sort of modelling you've done, what work has been done and what the time frame is?

Ms Rule: I think we've already answered the question about the time frame. The government is considering its response to this review. It has announced two recommendations that it will not implement, and the rest of the recommendations are under consideration by government.

Senator POLLEY: Changing the packages to 3-4s and taking away some of their 1-2s, what impact will that have on the aged-care provision ratio for 2017 going forward?

Mr Culhane: The targets for the aged-care provision ratio are set in relation to, I think, the 2020-21 year as a target. So the government hasn't set targets for all the interim years and hasn't varied the target for the 2021-22 year.

Senator POLLEY: So you have no targets?

Mr Culhane: The government has a target for 2021-22.

Senator POLLEY: And what about for 2019?

Ms Rule: No. It's a target that projects out into the future.

Mr Culhane: The government is working progressively towards that target.

Senator POLLEY: How many people do you expect to be added to the wait list by level each year compared to the number of packages by level?

Ms Rule: We can't project the future demand for home care.

Senator POLLEY: Bear in mind: how many people are still waiting? Surely, some modelling has been done when there are some 90,000 Australians still waiting for a home-care package?

Ms Buffinton: Can we just say also that the wait time—nobody was aware of how long the queue was, as we've discussed in previous estimates. Before 27 February, people waited for packages, but they waited at the door of individual providers, and some were on many lists. What we now have for the first time is transparency on what is a national queue. Through that transparency, that's when we as policymakers and the government we can start work to look at the relativities.

Ms Rule: Senator, the modelling that you are talking about underpins the ratio. The ratio is a projection of the number of people of a certain age accessing aged-care services. We've used population data to suggest how many people are likely to access services—or how many people are likely to be in an age range where they will require services. So that's the modelling that underpins the forward projections.

Senator POLLEY: Can you give us any information then on what you expect the wait times are going to be. There is some data. The data has been published. You must be able to give us some clarity about the waiting times now.

Ms Rule: The waiting times now are the waiting times that are in the report.

Senator POLLEY: Can we still expect, then, that a 92-year-old man who is waiting for a level 3/4 package will be told he has to wait 18 months? Is that what consumers can expect going forward?

Ms Rule: Every situation is different depending on the circumstances of that person—when they enter the queue. I can't speculate.

Senator POLLEY: But a 92-year-old man! One hopes he will still need that package in 18 months. There is no improvement for the wait times? We get calls into our electorate offices on a regular basis about people being told they are going to wait 12 or 18 months for a package. Even though you have this data, you can't give me any time frames to demonstrate that that is going to improve?

Senator NASH: Senator, weren't the home care packages allocated under your Living Longer Living Better reforms, under the Labor government?

Senator POLLEY: That was five years ago. You've been in government for four years!

Senator Nash: But that's when the allocation—

Senator POLLEY: You can't keep blaming the former government.

Senator Nash: We put \$5.5 billion into this budget to support older Australians.

Senator POLLEY: We did all the reform and you guys have done nothing. You couldn't even roll it out.

Senator Nash: It's interesting that you're not confessing that it was—

Senator POLLEY: What we've seen are three ministers who have achieved nothing.

Senator Nash: your allocations to start with.

Senator POLLEY: Three ministers have achieved nothing when it comes to reform.

Senator Nash: Anyway, I thought I might bring that to the attention of the committee.

Senator POLLEY: That's really helpful!

CHAIR: Thank you, Minister. Do you want to get back to questions, Senator?

Senator POLLEY: I'm waiting for an answer from the department. That was it? That's your answer? There is no way you can tell us, with the data, that there's going to be any improvement?

Ms Rule: I can't project what's going to happen into the future in terms of demand, other than to use those population models about the numbers of people that might need to access services, based on age.

Senator POLLEY: It was reported earlier this year by the minister that 212 people had been identified through the national prioritisation system as waiting over two years for a home care package. Are any of them still waiting for a package?

Ms Buffinton: I would have to look at those individual cases to comment.

Senator POLLEY: You will take that on notice?

Ms Buffinton: I will take it on notice.

Senator POLLEY: It also appears from the data that 16,180 people have been waiting for a package since 1 July 2016. Is this accurate?

Ms Rule: Given that the system of the current national queue has only been in place since 27 February, I'm not quite sure how we could tell from the data how long people have been waiting into previous years.

Senator POLLEY: Would you like to take that on notice?

Ms Rule: I'm happy to take that on notice.

Ms Buffinton: Yes, we can take that on notice.

Senator POLLEY: What's the average delay between a care recipient being allocated a home care package and that package becoming operational?

Ms Buffinton: Once they're allocated a package and we write to them to offer them the package, they have 56 days to make a choice. We send out a reminder letter. If they need more than 56 days, they can ring My Aged Care and ask for an additional 28 days. At this stage, I can't give you the average. I might have to take that one on notice.

Senator POLLEY: If you could, thank you. Given the significant delays for people to access packages, what's the department doing to better prepare recipients to access packages immediately so they don't need to use the 56 days—plus, I understand, a possible 28 days—provided to enter into a home care agreement?

Ms Buffinton: Firstly, we've been doing a lot of work with consumer and consumer groups and the Council of the Ageing to make people far more aware about the home care changes. When the ACAT comes to them they bring with them our full brochure on the introduction to home care. When we send out our reminder letter, we also put in a small brochure on helping them make their choices. If they do ring up the contact centre, the contact centre's scripting says, 'There are service finders to help you.' But instead of using the service finder—if you or your family or support person is not comfortable using the computer—the script says, 'I can assist you by describing what is available in your local area.'

Senator POLLEY: What date will the next *Home Care Packages Program data report* be released, and will it include all the wait time data?

Ms Buffinton: Our expectation is it will be around about mid-November—that will be for the figures through to 30 September— so it will be the next three-month version of that report. Remember there are 56 days, plus 28 days, and then a provider has up to 28 days to notify the Department of Human Services that the individual is in care. There is a big incentive for providers to notify quickly because that's when their payments start—but take into account that's effectively 112 days. We will be looking forward to seeing the 30 September figures, because that will give us a much better view of what's been happening since March.

Senator POLLEY: Approximately 50 per cent of all residential-care consumers had a diagnosis of dementia, according to the Department of Health 2015-16 report on the operation of the Aged Care Act. Do you know what proportion of home care and Commonwealth Home Care Support Programme consumers have a diagnosis of dementia?

Ms Rule: We would have to take that on notice. I suspect we don't collect that data.

Senator POLLEY: Isn't there a supplement to the home-care package for people who have been assessed and diagnosed with dementia? So you must have figures as to those payments.

Ms Rule: As I was in the process of saying, I suspect we don't collect that data for the Commonwealth Home Care Support Programme because it is a different type of program. It's a block-grant-funded program. For home care, we would have to take that question on notice—we don't have that data with us.

Senator POLLEY: The Tune Review reports 11,147 home-care recipients received a dementia supplement for 2015-16. How many received that supplement for 2016-17, and what percentage of all packages is this?

Ms Rule: I'd have to take that on notice. I haven't got that data with me.

Senator POLLEY: The department is allocating lower-level packages to people who have been assessed as eligible to receive Level 3 or 4 packages. Dementia advocates have raised serious concerns about this process and the negative impact on sufferers of dementia of being pushed to different levels of service and not being able to access the service they require. What's the department doing to support people in those circumstances?

Ms Rule: You'd be aware that there are a range of supports available to people. People are eligible to get an interim package so that they're not missing out on support until such time as they get onto their assessed level of package. They can be getting support either through the Commonwealth Home Care Support Programme or through a lower-level home-care package until such time as their assessed level of package becomes available.

Senator POLLEY: Can you give me any figures as to how many of those interim packages are being given to people diagnosed with dementia?

Ms Rule: We will have to take that on notice.

Senator POLLEY: The Tune Review also recommended the creation of a Level 5 home-care package to allow people with higher-care needs to stay at home longer—specifically living with dementia and palliative care needs. What's the government's view of this measure?

Has any work been undertaken by the department to analyse the option of a Level 5 package, and have you done any costings of that?

Ms Rule: Like all the other recommendations in the report, we are working through them and providing advice to government on those matters.

Senator POLLEY: Would you perceive that as perhaps being a medium- to long-term proposition?

Ms Rule: I can't speculate on that, Senator.

Ms Beauchamp: It's probably worthwhile adding that the government is considering all of these recommendations in the context of the broader work that's being done and led by Prime Minister and Cabinet on ageing. For your time frame, I would expect a government response some time early next year.

Senator POLLEY: In relation to that Level 5 package, if people were supported at home longer, rather than going into residential care, wouldn't that be a cost saving to the government?

Ms Rule: It depends on the level of support that was attached to that level 5 package. As you start to get into the higher value of packages, the gap between home-care packages and residential aged care, in terms of cost, reduces. Because government hasn't made a decision yet on what a level 5 package could look like or if we're going to implement that or any of those sorts of things, we can't speculate on the cost that would be attached to such a thing.

Senator POLLEY: But you have given some advice around that.

Ms Rule: We give a range of advice to government.

Ms Beauchamp: I guess the priority consideration would be quality service provision and continuity of service provision as well, not necessarily the financial implications upfront. Obviously they're important, but when you're looking at patient centred care you would be looking at the needs on a case-by-case basis and what's best for that individual.

Senator POLLEY: Absolutely, and it would be fair to say that there would be a lot of consumers who would prefer to have those services provided at home as long as possible, rather than going into residential care. On average, what percentage of the year is any home-care package unoccupied due to turnover?

Ms Buffinton: I think that concept really finished on 27 February because—we discussed that before, I think—of the 80,000 packages, often there were only about 60,000. This is because we used to give, through the ACAR, packages to different providers and, at any one time, only about 75 per cent of packages were filled. But now we've gone to consumer directed care the individual owns the package, so it has a different concept.

Senator POLLEY: If we go to cost recovery, I just want to clarify some of the things that were said, so I can get it straight in my own mind. Can you give us an update of the cost-recovery implementation statement and unannounced site visits, conducted by the quality agency on residential aged care homes, which are expected to commence on 1 July 2018, and clarify what that is going to entail?

Ms Laffan: The quality agency released their revised cost-recovery implementation statement for public consultation from 23 June this year to 25 July this year. Legislation has been drafted and is awaiting parliamentary processes.

Senator POLLEY: Have there been any concerns raised over the legality of these measures?

Ms Laffan: Yes, early on, with some of the feedback we received. I think that was around the fact that the services believed that a levy needed to be introduced. And that was correct. That was something we raised through the cost-recovery implementation statement that, as a compliance and monitoring activity, needed to be recovered via a levy act, and that's what we're currently working on.

Mr Ryan: And if it does pass the House and those processes, it will be lawful.

Senator POLLEY: Have providers been given any guidance as to what—what I understood before was that you were saying there is not going to be any change to the cost. Is that right?

Mr Ryan: No, that was—

Ms Rule: No, we were talking about a different charging regime, which was for accreditation.

Senator POLLEY: So what's the expected cost for these unannounced site visits?

Ms Laffan: According to the quality agency's implementation statement, it varies between service depending on the bed numbers. The cost varies between \$2,726 and \$5,878 per service, in 2018, noting the discounts that Ms Buffinton talked about earlier.

Senator POLLEY: What processes are in place to ensure only costs are recovered, and what processes are in place to ensure that costs are kept to a minimum and are efficient?

Ms Laffan: All cost recovery needs to be done in line with the Australian Government Cost Recovery Guidelines, and those guidelines require that only the costs to the agency for undertaking those activities be recovered for.

Senator POLLEY: Okay. Just so I have this straight, in terms of the implementation of the announcement made yesterday by Minister Wyatt that all assessment visits other than the initial accreditation visit will be unannounced, can you provide some detail about how the costs will be recovered?

Mr Ryan: I might take that. What Ms Laffan has said is regarding the new proposed levy for unannounced assessment contacts. We've always called them unannounced visits, and there are a number of those which are grouped there. What the minister referred to yesterday was government's intent that reaccreditation audits, which typically happen every three years, would move from being announced and scheduled months in advance to being unannounced. There was no change in the cost basis for reaccreditation audits. What Ms Laffan has just been referring to is a proposed cost recovery levy for the unannounced compliance visits.

Senator POLLEY: So will providers who receive multiple unannounced visits pay multiple times?

Mr Ryan: No.

Senator POLLEY: And will providers who don't have any visits still pay a fee?

Mr Ryan: At present, it will be a cost of one per year, irrespective of the actual amount. Where you have a home that's under close scrutiny, we may undertake a number of unannounced visits. If they're on a timetable for improvement, we may have an assessment

contact at the end of that timetable for improvement. Under current government policy, and under the law, every residential aged-care facility receives a minimum of one unannounced visit a year, so every home does receive it and did in the last financial year and is scheduled to do so this year.

Senator POLLEY: Okay. So can I have an update on the progress of the Single Aged Care Quality Framework, please/

Ms Laffan: Certainly. We conducted public consultations on a draft set of standards and options for a streamlined quality assessment process for six weeks between March and April this year. A range of communication and consultation activities were undertaken. Over 250 stakeholders attended our forums, with 750 log-ins to our webinar. We also received around 350 written submissions. The department has published a report on outcomes which is available on our website. We have continued to analyse and consider feedback from that consultation and have been making refinements to the standards as a result of that. We've been meeting with our technical advisory group to further refine, and we've been also meeting with stakeholder groups as well.

Senator POLLEY: So you've obviously had the consultation, and those results have obviously been collated, and there's been some revision. That was going to be piloted in the second half of this year. What revisions were made, and have the standards been piloted in any way as yet?

Ms Laffan: Certainly there have been revisions made to the standards as a result of both the consultation feedback and work with our technical advisory group. The standards have been tested for their measurability and assessability by surveyors from the quality agency, and the quality agency has also arranged for advice from an international expert on the assessment of standards, and they'd be able to talk further about further testing and piloting activities.

Senator POLLEY: So is everything all ready to commence from 1 July next year?

Ms Rule: I think we've said previously that we wouldn't move to implement the single quality framework until after the report from Carnell and Paterson was finalised, because we need to take into consideration the recommendations of that report in finalising the single quality framework. So, as part of the next steps of considering that report, we need to also consider the impact on the single quality framework.

Senator POLLEY: We have that report now, and we're talking about July next year. You're not confident that you'll have everything in place by then?

Ms Rule: We haven't done that analysis yet. As I said, the report was only released yesterday. We haven't had it for a long time before that, so we've now got a lot of detailed work to do around the implementation.

Senator POLLEY: So are you confident you'll be able to meet that time line?

Ms Rule: As I said, we'll need to go back and do some more detailed analysis about whether that's feasible and what kind of degree of change we need to make to the single quality framework to take into account the recommendations. Does that mean we need to undertake further consultation and piloting? That's the next step for us—to do that kind of detailed planning.

Senator POLLEY: Would you be expecting that you'd be able to give us an update in February in our next round of estimates? Can we look forward to that?

Ms Rule: Certainly.

Senator POLLEY: I want to move on to the quality agency, if I can. It was reported in June that, in response to the significant failures of those wards in Oakden which launched into an internal inquiry with consultation by the—is it the Nous Group?

Mr Ryan: Yes.

Senator POLLEY: That's appropriate! They're due to report by 30 June. Is that report public?

Mr Ryan: It is. That report is public, and it's available on our website.

Senator POLLEY: Excellent. On the basis of this report, can you detail what you believe were the causes for the failure of accreditation officers to identify the failures there?

Mr Ryan: Yes, I can, if you just give me one minute whilst I refer to my notes. Whilst I'm doing that, it's important to note that what we had done was discover serious noncompliance by the provider in March of this year. We had called serious risk in the home, reduced their accreditation to six months and found 16 outcomes that were not met. I, as a matter of urgency, announced that I would commission some independent advice. This was prior to the minister also undertaking a more thorough and comprehensive review of the regulatory system, which is the Carnell-Paterson report. I commissioned Nous Group to undertake this work. I was specifically wondering whether—certainly in February of last year, which was the previous full reaccreditation round—whether processes were appropriately found, followed and so forth.

Nous Group undertook a significant number of interviews, talked to a range of providers and looked at all of the assessment notes from the visit, and they came up with a number of findings. They found, certainly in the first instance, that Makk and McLeay was a fairly unusual environment. It's certainly not unique, but it is an unusual environment. It is for residents with the most challenging behaviours. A number of those residents had been residents in secure facilities for many, many, many years prior to them entering those particular wards. Clearly, what Nous Group found was that noncompliance of 10 years ago was not sufficiently drawn through in the way that we identified risks going forward and that they had received full accreditation in 2010. That's significantly earlier than the establishment of the current quality agency under the prior company. They also came back with recommendations about the way that we might identify risk and particularly dedicate staff to a home with a particular-needs environment, such as Oakden—or, in fact, the Makk and McLeay wings of Oakden. We also needed to understand whether they were forthright and genuine in the information they gave in 2016. So there is information, and it is available on our website, that says that some providers will game the system. I think that may be part of the Carnell-Paterson review that says we should move to unannounced reaccreditation audits to limit that kind of capacity.

Senator POLLEY: Do you take any responsibility for the failure of your organisation and the lack of confidence that the Australian people now have?

Mr Ryan: Certainly I was determined to get to the bottom of what occurred at the Makk and McLeay wings in 2016. The fact that we did find out what was going on before the

Groves report or the Oakden report ever came out, which I should put on record, and the fact that we didn't pick it last year was of concern. Clearly the major responsibility for what occurred at Oakden rests with the provider, but the public can be assured that our agency and the broader regulatory framework takes seriously that there were failures of appropriate care and, indeed, abuse. So we moved quickly, prior to the full Carnell-Paterson review, to undertake a full assessment of what happened. Nous made four recommendations about better risk based practices to better direct compliance monitoring and approaches, especially for these unusual high-risk services, and about having better draw-through of especially historic instances of serious noncompliance. So we draw that through in a far more transparent way now. We certainly want stronger capability of our assessors to make sure that in a fairly unusual environment we would allocate someone with a psychiatric nursing background in a facility such as that. Clearly we want our decision makers to take on board all of that information. Any failure of care in any residential aged-care facility is unacceptable. We are determined—and I think you can see that the government has been determined—to introduce whatever reforms are required to ensure the safety and wellbeing of residents.

Senator POLLEY: They're going to implement one so far that we're aware of out of that Carnell report.

Mr Ryan: We have already commenced implementing the Nous recommendations going forward. The implementations of those recommendations are underway as we speak and have been since July.

Senator POLLEY: So your explanation then is supposed to ensure that the public can now have confidence that things such as what happened at Oakden and the other things that we've been hearing about more recently won't happen again and that your accreditation processes now are thorough and that your surveyors are qualified to be able to make those assessments without any bias?

Mr Ryan: Yes. I can stand on our record of being able to deliver a robust accreditation system across 2,698 residential aged-care facilities. In the case of Oakden, it was a unique environment. We have certainly found areas for improvement. I have been determined, and my agency have been determined, to implement all the reforms under the current arrangements and under my powers as they exist. The Australian government and the minister were also determined to undertake a broader regulatory review. That report, with respect, came out yesterday.

Senator POLLEY: Yes, the report did come out yesterday and, yes, I've been briefed on it. There are 10 recommendations. Do you support all 10 recommendations?

Ms Rule: The report's a report to the minister, so it's not for officials—

Senator POLLEY: This is an agency that is responsible for ensuring that the Australian people have confidence that the accreditation of residential homes is of the highest standard.

CHAIR: Senator Polley, if you ask a question you should wait for the response.

Senator POLLEY: The person in charge of this should know whether or not he supports the recommendations—

CHAIR: Senator Siewert, do you have any questions?

Senator POLLEY: I haven't finished, sorry.

CHAIR: Then let the officer finish once you've asked the question rather than talk over the answer.

Senator POLLEY: I was asking the gentleman—

Mr Ryan: Senator, we had the opportunity to provide significant input and a submission and to have a number of meetings with the review. I'm absolutely satisfied that our advice going in is reflected within the report. The report makes a number of observations and findings, and we are still digesting those. We are supportive of the intent of the review and we will remain highly active working within our own agency and across government to inform government's consideration of this report. Whatever reform agenda the government sets, we will actively participate in that.

Senator POLLEY: Would it be fair to say that you believe that the announcement of unannounced visits would be an effective tool?

Mr Ryan: I don't normally provide opinions on that type.

Senator POLLEY: Have you ever raised any matters such as unannounced visits to government?

Mr Ryan: We have undertaken a range of conversations with the Department of Health, especially in the development of a single quality framework. In the event that government fully implements the unannounced reaccreditation audits, we believe that it would increase transparency and that we would work effectively within that framework.

Senator POLLEY: Is it true that unannounced visits are currently conducted over one day and not all outcome measures are assessed and that the capacity to identify issues with care quality is seriously limited?

Mr Ryan: This is the unannounced visits that you're talking about?

Senator POLLEY: Yes.

Mr Ryan: Yes. When we undertake an unannounced visit, we would normally target. We would look at the intelligence that we have. As you're aware, we have a close working relationship with the department and with the Aged Care Complaints Commissioner. We take on board any and all information that we receive from them about a home. We look at their accreditation history and we will typically look at particular modules and outcomes. We look at particular areas such as clinical care under standard 2, medication management, pain management and assessment, and we assess, on the vast majority, 1.6, which is human resource management. If there is anything about the performance at the home that would cause us concern and if we find any failure on behalf of the provider to meet any of those outcomes, we will conduct a review audit. We conducted many more of them this year. If we find that there's regulatory failure and risk to one or more nominated residents, we will call serious risk. We are diligent in undertaking those activities.

CHAIR: Could I interrupt for a second? Are we likely to be through this outcome by 9 pm?

Senator POLLEY: It depends. I have a few more questions and then I'm happy—

CHAIR: We have other senators who want to ask questions in the next outcome. I'd like to give them prior warning if we're not going to get there.

Senator POLLEY: If you allow me to continue, I'll be finished by about five to nine, depending on how long they take to answer the questions, of course. The review heard about accreditation by the quality agency that was more focused on outcomes and appeared to be just a tick-the-box exercise. Do you believe this was the case in the past or is it still happening?

Mr Ryan: I certainly acknowledge that that was the view of some stakeholders. That wouldn't be the view of the vast majority of providers. We certainly acknowledge that there is a range of views around whether our approach to accreditation meets everyone's needs. Our approach to accreditation is clearly guided by the law and by the regulatory framework that we implement. We don't believe that it's a tick-and-flick. We do find non-compliance. Where we find non-compliance by a provider, we name it and where necessary we call serious risk. Where we do find non-compliance, we are diligent and we will inform the secretary or her delegate of that non-compliance, so I don't accept that it's a tick-and-flick scheme at all.

Senator POLLEY: You don't accept that. It's been suggested that the agency takes a much lighter-touch approach to regulation of nursing homes operated by state governments. Have you seen any evidence of this, either formally or informally, in your investigations or do you believe this to be the case of any other accreditation staff?

Mr Ryan: No. We would not treat a home differently on the basis of it being run by a state government or any other particular subgroup of aged-care providers. In the case of the state government in South Australia, we certainly wouldn't have treated them differently on the basis of that, so I don't accept that there's any differential treatment, either operationally or culturally.

Senator POLLEY: The review states on page 46 that there are 57 facilities that have accreditation history matching that of Oakden. This is very concerning. I understand why the public is concerned. I understand why other providers are concerned. What's the agency doing with regard to these 57 facilities?

Mr Ryan: I have read, but I have not studied, that particular part of the report. So let me talk about what we have in fact done with regard to facilities such as Oakden.

Senator POLLEY: Well, no—you're saying, then, there aren't 57 facilities that are having—

Mr Ryan: I would have to review the report. It says that there are 57 homes with a historical profile of homes that returned to full compliance. I've just received a note from my colleague. In the case of Oakden there was serious noncompliance in 2007, 2008 through to 2009. They then did return to full compliance, and I believe that the Carnell-Paterson report talks about those. In the last 18 months, before the Oakden matter ever emerged, we have been much stricter in terms of homes with a history of poor compliance. We have an active case management approach that looks at historic instances of noncompliance and we have a very vigorous sharing of information between the department, the complaints commissioner and ourselves. So I do not accept that whilst there may be 57 homes with a history of noncompliance that returned to compliance, I don't believe that there are 57 Oakden homes today.

Senator POLLEY: I'm not saying they're Oakden; I'm saying that they have serious issues. Could you take it on notice then and provide to the committee all information relating

to those that have been referred to in the review, so that we can be assured that we're not going to have a repeat of the Oakden situation?

Mr Ryan: You would specifically like history on those 57 facilities?

Senator POLLEY: Yes.

Mr Ryan: Okay, we'll take that on notice.

Senator POLLEY: Thank you very much. In response to question SQ17-000865, you provided details on 591 failures to meet aged-care quality standards by residential aged-care providers between 1 July 2012 to 14 June this year. Do you think that around 100 failures per year over a five-year period is a large number of failures?

Mr Ryan: They're the failures that we found. We remain very vigilant to look at every aged-care facility. I can't really compare whether it's high or low. Clearly, in the last 18 months, we have sharpened our focus around the areas of serious risk where we find it—again, prior to Oakden emerging as a matter of public concern. So we have tightened our vigilance around noncompliance, especially where it contributes to serious risk to identified residents.

Senator POLLEY: Of the more than 500 cases that have been resolved, 278 of those took more than 100 days to put in place the required improvements to eventually meet the required standards. Does that seem like a reasonable proposition to you, that older people should expect to wait more than 100 days for failures to be rectified in their nursing home?

Mr Ryan: That's a good question.

Senator POLLEY: I thought so, too.

Mr Ryan: Yes, thank you. If we go in and we find—

Senator POLLEY: You might laugh, minister, but we're talking about older Australians who have a right to respectful care—

Senator Nash: No—I was laughing at the fact that you said you had a good question; your self-expression of your own good question. That was all I was laughing at, Senator. I take this issue very, very seriously.

Mr Ryan: A timetable for improvement: if we go into a facility and we find one of the 44 outcomes are not met, we firstly inform the provider. We are quite specific about the nature and the impact of the noncompliance by the provider. We are very clear to them about what rectification of the noncompliance needs to look like, and we often provide education. We then place a home on a timetable for improvement: that's a process under the principles whereby they are given very clear undertakings as to what they need to do to return to compliance. If we believe that one or more residents were placed at serious risk as a result of that noncompliance, we will call serious risk. Serious risk then triggers a formal notification to the secretary or her delegate and, in most instances—not every instance—they may make a finding of immediate and severe risk, and sanctions will be applied. The premise of the question—that people would have to wait for improvement with seriously underperforming homes—is not borne out by the process or by the evidence. Where there is a timetable for improvement but we don't find serious risk and we believe that we can work with the home to ensure that it moves back to compliance, that's the nature of the timetable for improvement.

Senator POLLEY: What do you consider to be serious risk? What's the criteria?

Mr Ryan: Serious risk is well defined under our principles. We take the dictionary meaning of both words 'serious' and 'risk' when used individually and together. We need to be able to identify how the failure against the standards impacted upon one or more residents. When we write to the provider and say we're contemplating a finding of serious risk, we identify those providers. We provide the clinical and observational evidence of how that failure directly impacted upon that particular resident and we would in most cases reach a finding of serious risk, which has significant implications for that home.

Senator POLLEY: In numerous examples it took more than 150 days to resolve failures. Do you think that the lack of either financial or criminal penalties for failures means that providers have little incentive to rectify these failures quickly?

Mr Ryan: I don't have a comment on the funding. I can say that the reputational loss for a home that's placed under serious risk, the application and financial impacts of sanctions—the notion that there is no incentive for providers to provide adequate care is not borne out by the experience. There are significant reputational and financial losses for a home that is placed on sanctions.

Senator POLLEY: How many nursing homes are currently on improvement plans as a result of failures of one or more of the 44 accreditation standards?

Mr Ryan: I'll need a moment on that.

Ms Rule: While he's looking that up, it's important to note there are financial penalties. One of the sanctions we can exercise is to stop paying Commonwealth subsidies to aged-care homes in instances of noncompliance. There are quite significant financial penalties that homes can—

Senator POLLEY: What impact does that have on the residents?

Ms Rule: It's a significant incentive for homes to return to compliance.

Mr Culhane: Even when the subsidies stop, providers continue to be obliged to meet all regulatory and quality-of-care requirements set out in the legislation. The department imposes a number of sanctions. As was mentioned, the department can cease subsidies. It can also cease any subsidies for new residents, which is used more commonly. That makes it quite difficult for a provider to bring new residents into the home. There are other sanctions around requiring the provider to provide training, to appoint a nurse adviser or to appoint a business adviser, all of which are quite costly.

Senator POLLEY: Last night on the ABC—

Mr Ryan: Would you like me to answer the timetable question?

Senator POLLEY: Yes, thank you.

Mr Ryan: This is the year to date up until the end of September: 23 residential aged-care facilities were still serving timetables for improvement and 40 more were placed on it since that period. The number of services that did not resolve all of the not-met periods by the end of the timetable for improvement was 21. The suggestion that there's no vigilance—this is evidence of vigilance against assessing them, placing them on timetables for improvement and assessing them carefully at the end.

Senator POLLEY: Last night on ABC's 7.30 program a woman by the name of Carla Baron identified herself as a former Commonwealth aged-care assessor and said:

Do you know what you need to pass planning and leadership? A written mission and values statement. So if you have on the wall, our mission is to look after old people in the best possible way, you will pass that standard.

Is this assessment correct, and if it is, what is the purpose of this standard?

Mr Ryan: I can't comment on Ms Baron's comment other than current registered assessors and surveyors undertake significantly greater scrutiny of standard 1.5. We look for much, much more than that on the wall and what Ms Baron had to say. We look at how the home ensures that the home's visions, values and objectives are documented, and we need to see the effect of that system in action. Merely having it on the wall—we look for evidence that the home can validate that organisational approach, and we test it and validate it in the way that they apply those principles or those policies and standards and in those operations throughout the home. We look for it in terms of the consumer experience interviews that we undertake. We ask them questions about the nature of the home. We certainly will ask a number of representatives of the employees of the home's front-line staff, clinical staff, people from the administration of the organisation. Having it on the wall is not sufficient to meet that standard. A currently registered surveyor knows that full well, as do providers.

Senator POLLEY: A large number of national providers of aged care services have announced a plan to restructure their staffing arrangements across a large number of nursing homes, in some cases combining the roles of care manager and clinical manager into one position. In general terms, can you talk us through the role that the agency has in terms of oversight of sufficient changes to staffing levels?

Mr Ryan: Changes to staffing models is something that we watch very, very closely. People sometimes ask us what the areas are that would focus our interest on a particular home or a group of homes. A change to the staffing model or a change to the resident mix would be included. We assess expected outcome 1.6. It requires a significant investigation and evidence from a home to show that their care model and their staffing model meets the clinical need of the resident mix of the day, and that it provides sufficient scrutiny around recruitment, around police checks, around continuous improvement, around professional development and monitoring of staff. It looks to ensure that there are the right clinical staff to deliver the range of expected outcomes in standard number 2. And it looks for validation that there is sufficient staffing throughout the day and night to meet the care needs of those particular residents. So a change to a broad system is something that we would look at very, very closely. If we believe that change is system wide or group of homes wide, we would then tag that for the next unannounced visit or reaccreditation audit for the rest of the homes in that group.

Senator POLLEY: Do you have any concerns around the consistency or quality of training that accreditation staff receive, and does the use of contract staff undermine the consistency of quality assessment?

Mr Ryan: We have a rigorous continuous professional development—there's a mandated 15 hours a year of ongoing professional development. There's a thorough course that new surveyors need to undertake. We are vigilant in terms of ongoing training around emerging matters, around emerging patterns in care needs of residents and of the statutory decision making, especially around serious risk, which I have mentioned a few times tonight. It's important to know that the International Society for Quality in Healthcare, which accredits our accreditation scheme and a number of accreditation schemes throughout the world in

health accreditation—in June of this year we too were surveyed by ISQua and we received the advice of ISQua then that we received 91 per cent on an internationally benchmarked scale. We received 91 per cent from ISQua in terms of our scheme.

In terms of contract surveyors, contract surveyors also need to undertake CPD. They need to undertake a minimum amount of ongoing development and they need to serve a number of visits each year. The nature of the reaccreditation round, which is a big curve of activity going forward, is the reason why we retain contract surveyors. Due to the success of our enterprise agreement we have consolidated functions amongst our staff and we would anticipate less reliance upon external contract surveyors going forward.

Senator POLLEY: My final question arising out of that is, when you have your surveyors, do they have allocated areas geographically that they do their accreditation in, or do you rotate around? For instance, is the same surveyor doing all of Tasmania, or do they do half of Tasmania, or do they mix it around?

Mr Ryan: Our operation is based on state officers in Perth, Adelaide, Melbourne with an outpost in Tasmania—with a basis in Tasmania but they're part of that outfit—in Sydney and in Brisbane. We would tend to mix up, especially a home that has a history, we would look to mix up surveyors based on availability. Also, surveyors have a very strict conflict of interest declaration requirement. If they've worked in a home before or in the recent past they will never be assigned there. We will always team each visit based on the specific care needs of that home. If we had particular interests or concerns around clinical, if they have a history of clinical non-compliance, we would always have a more senior nurse, so we would mix and match according to the specific needs of each home.

Senator SIEWERT: Mr Ryan, when you were answering the questions from Senator Polley around the Oakden matter, you were making a point about providers gaming the system. Could you complete the point you were making on that area? You then went on to make another point, but you didn't finish that point.

Mr Ryan: There's always a risk, with any accreditation or regulatory system, that some people intentionally provide inaccurate or misleading information about their performance. Our system's rather rigorous, and that's why we always triangulate it by gathering data with confidential interviews with residents and their representatives. We need to look at the documentation and we need to interview homes. That is one of the things you'll find has been considered in the Carnell/Paterson report, and no doubt government will look at that particular component in terms of ongoing regulatory reform of the aged care system.

Senator SIEWERT: How you reduce that gaming?

Mr Ryan: How we always look for opportunities to be tighter and more focused to ensure the safety and wellbeing of older Australians, especially in residential facilities.

Senator SIEWERT: You were making the comment in response to Senator Polley's questioning about Oakden. Can I draw a conclusion that you thought what was happening?

Mr Ryan: I would draw your attention to the report of Dr Aaron Groves and his co-authors. That was clearly his assessment and conclusion, and I have no reason to vary my opinion from his.

Senator SIEWERT: Could I ask a specific question about dementia funding. What I'm trying to find out is the total spend on dementia. Does anybody pull that together?

Ms Rule: I think the answer is no. As you can imagine, there's a range of funding programs for dementia under aged care. There are also funds provided at state level through the health system. There's funding provided through Medicare. There's a whole range of funding sources.

Senator SIEWERT: I should make that more specific; I apologise for that. I understand what you've just said, but in terms of funding that is specific dementia funding through the department, do you pull that overall amount together, and, if you do and I can find it somewhere, can you point me to where I can find it?

Ms Rule: We can certainly give you that figure for funding provided through the aged-care system.

Senator SIEWERT: Yes, for all the different components pulled together.

Ms Rule: Yes, we can take that on notice. I've got a number of briefs so I could tell it to you now, but I think we are going to run out of time.

Senator SIEWERT: Yes, we are. So can I ask, on notice, can you pull that together over the last, say, four years? Is that too big a task?

Ms Rule: No, that is reasonable.

Senator SIEWERT: That would be appreciated. I have some quite detailed questions that I was going to put on notice, before you have a heart attack.

CHAIR: Senator Smith, do you have questions?

Senator SMITH: I have two questions briefly, if I may, to Mr Ryan. Mr Ryan, you didn't need the independent review to alert you to the issue of gaming, did you?

Mr Ryan: No, it is an area that we are very concerned about.

Senator SMITH: And alert to, and this is really a validation of that?

Mr Ryan: Thank you, Senator. This was a validation. Our move towards the computer-assisted audit tool was to have more specified outcomes that we looked for, and we have been vigilant in finding that. Certainly before Oakden our findings of serious risk had increased and we had sharpened our regulatory approach for the last 18 months.

Senator SIEWERT: Just for the record, I wasn't implying that.

Senator SMITH: No, my questions are completely independent of your line of questioning, Senator Siewert. My second question was that you mentioned that the regime had been internationally accredited with a score of 91.

Mr Ryan: Correct.

Senator SMITH: I don't like to assume in this business, so is it 91 out of 100?

Mr Ryan: Yes, 91 per cent, Senator.

Senator SMITH: That sounds impressive, so I'm assuming that 91 is well above similar regimes.

Mr Ryan: I have asked the question of my colleague, Ann Wunsch, who is a surveyor for ISQua, as well as my executive director of operations. They don't normally tell everyone what they get, but I'm happy to be above 90 per cent, Senator happy. I don't have a comparative benchmark, but we will take that on notice.

Senator SMITH: That would be great. Sorry, Chair, one last point. When you move around the industry we hear lots of talk about the professionalisation, if you like, of the accreditation system, that is, third parties being employed by providers to come in and assist with the accreditation system. Is that a good thing, a bad thing, or you're indifferent to it? Does Minister Wyatt's announcement put an end to those sorts of things?

Mr Ryan: I would think that the minister's announcement to unannounced reaccreditation audits, which I fully support, by the way, would say that there is a lesser risk of the notion of being able to game it by looking good for a week or two.

Senator SMITH: Well, less opportunity for that.

Mr Ryan: Yes. I think, as the minister had said, we are interested in 365 days a year, and knowing that we will be there one day but not knowing which day, they may well end up doing well every day because that could be the day. The use of external consultants, many businesses engage consultants—

Senator SMITH: Not necessarily a bad thing.

Mr Ryan: No, not necessarily a bad thing. If it helps them improve their actual performance, we think that's a good thing, and we all seek advice from specialists in our line of work from day to day. If it helps them put a spin on it, then we're not happy with that, and we think that the minister's decision will assist with that.

Senator SMITH: You are looking for the lasting change?

Mr Ryan: Yes, of course.

CHAIR: Senator Polley, one question and then we are ending outcome 6.

Senator POLLEY: This is going back to home-care packages. I want to make sure we have this correct. Can you tell me what is the average expected wait time by package level 1 through to 4 and by assessed priority, medium or high? Expected wait times were not available when the data report was published but now they are available to consumers through the My Aged Care portal.

Ms Buffinton: Senator, we can't provide average wait times at this stage.

CHAIR: On that note we will end outcome 6 and release the officials from that outcome. We will go into a brief suspension and resume at 20 minutes past nine.

Senator POLLEY: And we will put our questions to the Aged Care Commissioner?

CHAIR: Absolutely. Thank you.

Proceedings suspended from 21:04 to 21:20

CHAIR: We resume with regulation, safety and protection. Senator Farrell, have you got questions in that outcome?

Senator FARRELL: No, I'm waiting for sport, Chair.

CHAIR: Well, I know that your colleagues do

Prof. Murphy: Chair, if you like, I would like to make a statement in relation to outcome 5 and the immunisation question this morning.

CHAIR: That sounds like a great idea.

Prof. Murphy: When questioned this morning about meningococcal B vaccine, I think I was somewhat confused by the reference in the question to 'fast-tracking' which is not relevant for meningococcal B but is relevant for ACWY. I can confirm, having read that article, that the minister certainly did ask me to consider the adoption of meningococcal B vaccine in the National Immunisation Program. That request was made to me at that time and we did, subsequently, have many meetings with the sponsor of the drug, the provider of the drug, as did the minister, and we have strongly encouraged the company to resubmit to the PBAC, and, to date, they have not done so. We continue to encourage them and, if they did make a submission, we would certainly consider expediting an assessment of that process. I just wanted to make it clear that, as quoted in that article, the minister certainly did ask me to do those things and I did do those things.

CHAIR: What's the dynamic, the pressure, here? Why wouldn't they resubmit?

Prof. Murphy: As we alluded to earlier, they have failed in the past because they couldn't produce sufficient evidence of cost effectiveness, and they are gathering—

CHAIR: So, they might want to build up more evidence to ensure that next time—

Prof. Murphy: That they get through next time, yes.

CHAIR: Thank you very much. We move to outcome 5. Senator Singh, you have the call.

Senator SINGH: Thank you very much, Chair. I would like to ask some questions, firstly, about PFAS. You would be aware that, in Katherine, a water treatment plant is being installed to treat drinking water for PFAS, and in previous investigations these steps were taken after investigation results were known. If the drinking water supply is at risk, enough for a water treatment plant to be installed before the investigation results are even known, why is the department delaying the offer of blood tests to the Katherine community?

Prof. Murphy: At the moment, with blood testing, there is no clear value in doing blood tests outside of a situation where there has been a completed formal human health risk assessment, as there has been in Williamstown and Oakey, and in the context of us doing an epidemiological study at Williamstown and Oakey. Blood testing has no predictive value, it has no proven value, but it is being done in Williamstown and Oakey as part of the government's comprehensive study to determine if there is any evidence at all of any adverse human health effects, because there are known proven adverse human health effects. It would be premature to offer blood testing to the Katherine residents. We haven't finished the human health assessment, we don't know the exposure pathways and blood tests are of no predictive value to that community. Once the human health risk assessment is completed this could be reconsidered.

Senator SINGH: What kind of research or activities are being undertaken by the department?

Prof. Murphy: There is an epidemiological study, as I mentioned, which is being run by the Australian National University, at Williamstown and Oakey, and that is a comprehensive study of all the disease patterns in that community.

Senator SINGH: Where is that study up to?

Prof. Murphy: That study has commenced, but it's still under way, so—

Senator SINGH: How long will the study take?

Ms Appleyard: That study commenced last year and will complete around 2020.

Phase 1 of the study involved a detailed literature review by the ANU in order to look at the body of evidence existing around PFAS. That builds on work that was also done by FSANZ in developing the health based guidance values. That literature review was recently delivered to the department. There is a phase 2 study protocol as well. It is what we call a direct source tender. The Australian University is being asked to come up with a protocol that will look at the how it will conduct the epidemiological study. So there will interviews of the people living in the area and an examination of registries and data bases to look at what the disease burden is in the community and whether or not there may be any link to PFAS exposure. The epidemiological study will incorporate the results of the blood test.

Senator SINGH: Sorry?

Ms Appleyard: The epidemiological study is linked to the blood testing.

Senator SINGH: The blood testing that you're not doing?

Ms Appleyard: In Williamstown and Oakey we are doing blood testing. The epidemiological study is being conducted in the communities of Williamstown and Oakey.

Senator SINGH: So why not do them in Katherine?

Ms Appleyard: As Professor Murphy said, a human health risk assessment has not been completed in Katherine. A human health risk assessment enables us to understand what the exposure pathways are for PFAS and the extent of those exposure pathways. Once we understand those we have a much better understanding as to whether or not there may be a need. It would be a decision for government in relation to extending the blood testing program.

Prof. Murphy: The government has committed \$12 ½ million to the NHMRC for a targeted call for research and has appointed an independent expert panel to guide those areas of research. That panel is also going to do yet another independent review of all of the literature to confirm the current finding, as the FSANZ literature review did, that there is no consistent evidence of any adverse human health effects of PFAS at this time.

Senator SINGH: Why was Williamstown and Oakey chosen for blood tests?

Ms Appleyard: Williamstown and Oakey were chosen because they were the first communities into which the Department of Health had done detailed risk assessments—human health risk assessments and ecological risk assessments. Because of those assessments, we understood, as I mentioned before, what the exposure pathways were and whether the population may be being exposed to PFAS, which would generally be through food, through

the ground water or through the drinking water supply. Knowing that and knowing the extent, the decision was based on that. So that was the trigger.

Senator SINGH: Have you got done a risk assessment of Katherine?

Prof. Murphy: That's in progress at the moment. The other point, as I made before, is that Williamstown-Oakey is done in conjunction with the epidemiological surveys, so the two can feed into each other.

Senator SINGH: When will the risk assessment in Katherine be completed?

Ms Appleyard: We would expect that, in the next few months.

Senator SINGH: And then you'll make a determination to offer blood tests?

Ms Appleyard: That would be a decision for government based on the results of the risk assessment.

Senator SINGH: So you waited until the completion of the risk assessment to offer the blood tests to Williamstown and Oakey? Is that what you're saying?

Ms Appleyard: What we're saying is that the human health risk assessment forms an important evidence base upon which it would be determined whether blood testing should be offered.

Senator SINGH: No; I'm talking about Williamstown and Oakey.

Ms Appleyard: In Williamstown and Oakey, yes, that's correct. The human health risk assessment had been undertaken and it was based on that. The voluntary blood testing—

Senator SINGH: Had the risk assessment been completed before you offered the blood tests?

Ms Appleyard: The risk assessments were certainly underway.

Senator SINGH: But they weren't completed, were they?

Ms Appleyard: That announcement was made at the time that this was all in the hands of the Department of Defence. So I would have to take that on notice in terms of timing. The voluntary blood testing program and epi study have transferred to the Department of Health from the Department of Defence.

Senator SINGH: I don't understand why you don't offer the blood test to the Katherine community, considering the risk assessment is underway, exactly the same as in Williamstown and Oakey, and that's what the community want.

Prof. Murphy: But there is no proven value in doing blood tests if—

Senator SINGH: Then what are you afraid of?

Prof. Murphy: The only concern would be creating unnecessary anxiety in the community, because there is no predictive value—

Senator SINGH: The anxiety is already there.

Prof. Murphy: The anxiety is there but it could be heightened. Every one of us has PFAS in our blood.

Senator SINGH: I'm going to move on, because of time, to codeine. Regarding the up-scheduling of codeine, can you confirm that this will still happen on 1 February 2018.

Dr Skerritt: Yes. The legislative instrument that's been made specifies 1 February 2018 as the commencement date.

Senator SINGH: So it will still happen on 1 February?

Dr Skerritt: Yes.

Senator SINGH: According to reports, several Liberal MPs are opposed to the change, and Minister Hunt told the Liberal party room that this is basically an issue for the states and territories. Is that the government's position?

Dr Skerritt: I don't know whether or not it's the government's position but it's the law of the land. Scheduling decisions are implemented through state and territory legislation. We don't have any indication from any states or territories that they're going to do anything other than adopt by reference the Commonwealth's decision.

Senator SINGH: Okay. Has there been any work undertaken with the department on the possibility of up-scheduling the delay?

Dr Skerritt: Delaying the up-scheduling?

Senator SINGH: Yes.

Dr Skerritt: We have to be responsive to a submission to delay the up-scheduling, and no such submission requesting a delay—a formal submission; there's a process in place—to the secretariat of the Medicines Scheduling Committee has been received.

Senator SINGH: So no correspondence or discussion about—

Dr Skerritt: There was correspondence from some stakeholders, such as the Pharmacy Guild of Australia, early on that floated the possibility of delaying the date. The New South Wales Pharmaceutical Society has also emailed us. It is open to anyone, any citizen of Australia, to propose a delay to that date. It then goes to the committee to look at that issue on the merits. But no formal submission has been received.

Senator SINGH: Therefore the committee's not looking at any delay?

Dr Skerritt: No. The committee meets once more before 1 February and their agenda is finalised.

Senator SINGH: Is this the Nationally Coordinated Codeine Implementation Working Group?

Dr Skerritt: No, the NCCIWG is a body that was set up, an organisation that was set up, involving all sorts of stakeholders—various clinical stakeholders, the Pharmacy Guild, the Pharmaceutical Society, NPS MedicineWise, states and territories—to work on the communication of the implementation of the decision and the impacts of it to everyone from a pharmacy assistant or pharmacist through to people in the community. It's a communication vehicle designed to communicate a decision that has already been made. It is not a forum for relitigating the decision.

Senator SINGH: How many times does NCCIWG meet and when did it last meet?

Dr Skerritt: I know it last met this week, but I'll ask Professor Greenaway if he could respond.

Dr Greenaway: It's met 10 times, most recently yesterday. There have also been a series of subcommittees involving the states and territories, consumers, pharmacists and medical practitioners.

Senator SINGH: In September the Pharmaceutical Society confirmed that additional funding had been provided to both them and the Pharmacy Guild to undertake training and communication activities. How much was provided to each of those organisations?

Dr Skerritt: No funding has yet been provided to them, because an agreement has not been finalised. The announcement in September was a figure in the early \$200,000s, and that was to undertake communication activities to pharmacists. They're reasonably well through the training but, like a lot of things, they have done it on faith, because they have not yet signed the contract.

Senator SINGH: Okay. What different activities will they undertake to do, compared with the TGA?

Mr Hawkins: The work that we've got the Pharmacy Guild and the PSA working on will be a range of communication products to go out to pharmacists and pharmacy assistants. They shared some of that work with us this week. There's a covering letter to explain the changes associated with the up-scheduling of codeine. There are a range of what we call decision trees—that is, how a pharmacist might approach someone who presents come 1 February. They've also been sending out different leaflets and training materials. On that, it's probably worth—

Senator SINGH: All for the up-scheduling?

Mr Hawkins: Correct.

Senator SINGH: Have any other organisations been funded as well?

Mr Hawkins: NPS MedicineWise have been funded. They've been dealing with a more generalised communication campaign on social media. So there has been a range of products they've put together on Facebook. They've been putting some general videos on YouTube with people's different patient stories around codeine and general information around lives and families that have been affected by people who have had issues with codeine.

Senator SINGH: Anyone else?

Dr Skerritt: There are a number of organisations that are in discussions with government about involvement, and they're the obvious ones, ranging from people involved in rural health care, people involved in—

Senator SINGH: Can you take it on notice to provide the list of organisations that will be funded?

Dr Skerritt: I would be delighted to, because I would expect in the next couple of weeks that will all be finalised.

Senator SINGH: Thank you. The TGA announced its final decision to up-schedule codeine in December last year.

Dr Skerritt: Correct.

Senator SINGH: It's only now about three months, I think, until the up-scheduling takes effect, so why has this activity been left so late?

Dr Skerritt: I would disagree with your assertion. As Professor Greenaway stated, NCCIWG, the communications group, working through a group such as NPS MedicinesWise, including our own communication activities, have been active since early 2017. So public communication materials went out as early as about April this year. The advice we have—

Senator SINGH: What are the government's communication activities?

Dr Skerritt: What the TGA is doing, as part of the Department of Health, is an information hub that has, for example, information if you're a rural resident or a rural prescriber. So, for example, it tells you about nurse prescribers—or nurse practitioners, as I should call them.

Senator SINGH: Where is this information hub?

Dr Skerritt: It is available on the TGA website.

Senator SINGH: So it's a website update.

Dr Skerritt: It's more than a website update. I think that's probably a superficial description of it. It is a set of information developed in conjunction with healthcare communication professionals, workshopped together with a broad spectrum of clinicians, pharmacists, states and territories and stakeholder groups to address the communication needs of their stakeholders.

Senator SINGH: What about someone who doesn't regularly log on to your website?

Dr Skerritt: This is the role, therefore, of other organisations, ranging from the work that we've just heard about from the guild and the Pharmaceutical Society. NPS MedicineWise receives tens of millions of dollars a year in funding to conduct very broad community education campaigns. In fact, most of us will have seen the bus shelters with the orange-and-purple signs about not taking antibiotics if you don't need them. Their role—and they're a central partner to this—is in the grassroots communication. Their communication professionals and others said, 'Don't do all your communication in April 2017 about something that's going to happen in February 2018.' People will want to know about this in the last month or so of this year and the first few months of next year when it's actually happening. If we tell them a year out, they'll say, 'That's a year away. I'll forget about it.'

Senator SINGH: So the TGA made this decision, but the only thing that the government is doing to communicate this decision to the public is through updating its website.

Dr Skerritt: No. I think, again, I would—

Senator SINGH: The government itself, I mean. I'm not talking about funding to organisations; I'm talking about what the government is doing.

Dr Skerritt: The government is doing more than just updating a website. The government has met regularly with states and territories both face to face and by telephone from 20 December for—I would have lost count—I think probably eight or nine times.

Senator SINGH: What do you mean by 'states and territories'? Who?

Dr Skerritt: The senior officials who are responsible for regulation of medicines. We have talked about what they have been doing as far as local communication within their states and territories. There's a range of groups, whether it's PHNs that have active programs of communication, whether it's the state and territory health departments. They've also worked on communication with their own political masters on the codeine decision. So the states and

territories have already been extremely active. There have been a range of other partners. As I mentioned to you on notice, you'll be provided with a map of seven or eight organisations that, in this December to February to March period, will be extremely active.

Senator SINGH: But there is no government advertising outreach itself.

Dr Skerritt: There is no government campaign, because this is a regulatory decision not made by a minister, not made by a member of parliament. It's a regulatory decision made by a senior doctor at arm's length to government. Because it was not a government political decision, the nature of it being a government campaign would not be appropriate. However, the groups who are charged with communicating politically neutral decisions—such as, 'Don't take antibiotics when you don't need them'—were seen as much more appropriate partners and delivery mechanisms. The doctors and pharmacists themselves are much more appropriate delivery mechanisms. Rather than turning on your television and seeing an ad about this, it's more appropriate if someone, walking into a pharmacist, gets a leaflet. Or there's a video running in the pharmacy. That is going to be much more effective.

CHAIR: I want to run through a couple of issues with the Office of the Gene Technology Regulator. On your website you use the phrase GMO—genetically modified organism—a lot. Can you talk us very briefly through how that is defined under the act?

Dr Bhula: A genetically modified organism is one where it has been produced through the use of gene technology—through some form of genetic modification. Generally, in the way that the legislation has been crafted, that is taking genetic material from one organism and putting it into another one. That organism that is modified through that technique must be live and viable, and the modification that's been made to the organism must be able to be inherited in the next generation. Broadly, that's the criteria that we use to define GMO.

CHAIR: That was my understanding as well. Would newer genetic techniques that have started to become widely discussed over the last few years—gene editing, the use of something like the CRISPR technology—fall under the banner of GMO? By that definition, I would have thought not.

Dr Bhula: The trigger for the gene technology scheme is whether you've used a genetic modification technique at all. If you're doing gene editing or you're adding genetic material from one organism into another, that's use of the technology, so that automatically puts you within the regulatory scheme.

CHAIR: It does?

Dr Bhula: It does, yes.

CHAIR: Okay, sorry. I thought in your definition you talked about taking genetic sequences from one organism and putting them into another.

Dr Bhula: That is to form a GMO, but we also have the trigger for the Gene Technology Act, which is the use of any form of genetic modification.

CHAIR: So that is the trigger?

Dr Bhula: That is the trigger, and then we talk about the organism that is formed as a result of having used genetic modification.

CHAIR: So, in a sense, that second plank that you put in there probably will become less relevant over time?

Dr Bhula: That really depends on where the technology goes. At the moment, as you described, when we're looking at gene editing that's using technology just to do work within one organism, you're not introducing any foreign DNA into that organism. As the technology develops, I guess, we'd be looking at those definitions about using the technology to form an organism and what that organism can do. We would be looking at that through the broader review of the gene technology scheme. It's something that could be looked at.

CHAIR: Do you take an oversight into all research projects in this space currently underway in Australia?

Dr Bhula: That's right; we do. There are certain points at which the regulatory scheme interacts with research. If you are importing an organism from overseas, you require not just a biosecurity licence from the department of agriculture but also a licence from the OGTR to be able to do activities with that particular organism. The facility that uses that organism has to be accredited by the OGTR. Depending on the sort of activity that you're doing, that then determines whether you fall in under a category of a low-risk dealing or activity, or whether you need to apply to the OGTR for a particular licence to undertake particular types of research and activities.

CHAIR: Do you look at projects based on the general areas of health, medicine, agriculture? Do you divide up projects on that basis? If so, can you give us some sort of numerical idea on what projects are happening in what areas?

Dr Bhula: We'd have to take that on notice.

CHAIR: Okay.

Dr Bhula: But the span in terms of the sorts of organisms and the applications that come to the office—they are very broad-ranging. It ranges from agricultural crops and commodities to work with laboratory animals, micro-organisms like yeast, viruses, and human cell therapies and the like.

CHAIR: In terms of your role, your regulatory oversight, is there an in-built review process? You talked about a review. Is there a review point coming up?

Dr Bhula: That's correct. Within the Gene Technology Act there's a provision for review every five years, and that's basically to keep up with new technology and whether the scheme and the act remain contemporary.

CHAIR: When's the next cycle?

Dr Bhula: We're in review at the moment. I don't know whether our colleagues from policy area want to come along and talk about the review.

CHAIR: If you could just talk me through the timing. I don't need exact dates but just a broad idea of the time frames. Are we out to public consultation at the moment?

Ms Shaw: Yes, there is a review that's commenced and is underway. We've just finished the phase 1 consultation process. That was a written submission process and that has now closed. We soon will go out to a second phase of consultation, which will involve workshops and that sort of methodology, to collect more views from a range of stakeholders. That will progress into early next year, and we expect a report by mid-next year.

CHAIR: How many submissions did you get?

Ms Shaw: One hundred and nine.

CHAIR: Thank you. I think that we can release outcome 5 unless there are any objections. We're moving to outcome 3, Sport and Recreation.

[21:48]

Senator FARRELL: Chair, I have some queries about the program. I know the government's not very interested in sports policy and that we were originally scheduled to start this program at 9.15 and it's now 9.50.

CHAIR: Goodness! I think we're doing well compared to some other committees that I've been sitting on!

Senator FARRELL: One of the duties of the chair, of course, is to try and stick to the program.

CHAIR: You should talk to your colleagues.

Senator FARRELL: Can I assume that I still have 60 minutes?

CHAIR: We are here until close if that's when we need to be.

Senator FARRELL: Thank you. Welcome, Ms Beauchamp, and congratulations on your appointment. Minister, I know it may be your last day in parliament—

Senator Nash: Steady!

Senator FARRELL: but would you mind showing a little bit of respect and at least looking interested.

Senator Nash: I am very interested.

Senator FARRELL: Thank you, minister.

Senator Nash: I am very interested and I can actually multitask.

Senator FARRELL: Let's hope so.

Senator Nash: Indeed, I can.

Senator FARRELL: I have some questions about the National Sport Plan. Perhaps you might like to take this question, Ms Palmer. When Minister Hunt announced the Sport Plan, he also referred to a lottery as one of the mechanisms to try to increase sports funding that the government had cut in previous budgets. He indicated, in both his public and his private communications, that he'd had preliminary discussions with two Labor and two Liberal sports ministers. Can you recall him saying something along those lines?

Ms Palmer: No, I can't, but my colleague Lisa Studdert might.

Dr Studdert: I think we canvassed this question last time we were here, and, as it was last time, we don't have information on those particular meetings.

Senator FARRELL: Right. Have you been following the debate at all?

Dr Studdert: Yes.

Senator FARRELL: Good. Is it fair to say that, firstly, since the minister announced the Sport Plan at least two state ministers have come out and rejected the idea of a national lottery and, secondly, no state minister has come out and publicly supported the proposal?

Dr Studdert: There have been a range of discussions, and they've been reported in a range of forums. I'm not going to add any additional commentary to that. We are working on advising the minister accordingly, and that's probably the extent—

Senator FARRELL: Just a moment ago, I asked you whether you've been following the debate.

Dr Studdert: Well, I have, but I'm not trying—

Senator FARRELL: And you haven't seen any state ministers come out and be critical of the idea of a sports lottery?

Dr Studdert: As I said, I think there have been a range of comments. We've followed them as, obviously, you have, and it's really not my place to add any additional comment to that.

Senator FARRELL: Why not?

Dr Studdert: Because we're here to advise about the business of the department in relation to that, and that's not—

Senator FARRELL: Yes, but you're dealing with the National Sport Plan. Is that correct?

Dr Studdert: Correct.

Senator FARRELL: And your job is to implement the government's policy in respect of the National Sport Plan. Is that correct?

Dr Studdert: That's correct.

Senator FARRELL: One of the aspects of that National Sport Plan is the government's suggestion of a national lottery to fund sports and other things. Is that correct?

Dr Studdert: That is correct.

Senator FARRELL: Are you telling me that you can't tell us what the position of the states is in relation to that proposal?

CHAIR: No, the official wasn't willing to comment on media commentary, Senator Farrell.

Senator FARRELL: Chair, please. I know you're a very new chair, but I'm asking the questions and you can get your chance later on.

Senator Nash: That's not worthy of you, Senator Farrell.

Senator FARRELL: I beg your pardon. I missed that.

Senator Nash: I said, 'That's not worthy of you.' We all start somewhere; we're all new at one point.

Senator FARRELL: I think the best way to start is with some good little habits, and the best habit is to let the questioner complete the question and not interfere.

CHAIR: We allow a lot of latitude in this committee.

Senator FARRELL: That is my suggestion.

Senator Nash: Which you can accept or not, Chair.

Dr Studdert: Senator, I'm not quite sure I know what the question is. As you've indicated, though, our advice is—

Senator FARRELL: I'll repeat the question then, if you're a bit unclear as to what I'm asking. What I'm saying to you is that you are responsible for advising the minister in respect of the National Sport Plan. One of the aspects of the National Sport Plan is a proposal for a national lottery to try and provide some funding for the government's cuts in sports in other

areas. What I'm trying to ascertain is: what feedback have you received from the states? I'm assuming that you're having some conversations with the states about what their attitude to this is. My understanding—and all I want you to say is 'yes' or 'no'—is that two states have now come out and opposed the lottery and, more importantly, no state has come out to support the lottery.

Dr Studdert: I can clarify that we have not been having conversations with the states about the lottery. We have been formulating advice for the minister about the lottery. The minister did have a meeting with his state and territory colleagues in August.

Senator FARRELL: Were you present at that?

Dr Studdert: I was not personally present. My colleagues here were.

Senator FARRELL: Mr Smith, you were present at that?

Mr Smith: Yes.

Senator FARRELL: Can you tell me whether or not any of the states came out in opposition to the lottery at that meeting.

Mr Smith: I could only refer you to the communique of that meeting. I don't think I'm at liberty to discuss the content of what was discussed around the table.

Senator FARRELL: You're not aware of any public statements by states?

Mr Smith: Public statements?

Senator FARRELL: Yes.

Mr Smith: I'm aware of reports in media about views of certain ministers.

Senator FARRELL: What have you discerned from those public reports?

Mr Smith: That there are a range of views.

Dr Studdert: Senator, as you expressed, there are a range of views, but that's really kind of irrelevant to the work that we are doing, which is to provide advice to the minister on the options for delivering the national lottery.

Senator FARRELL: Yes, your job is to implement the National Sport Plan. That involves the states, I assume.

Dr Studdert: We have consulted with the states about that, yes.

Senator FARRELL: I'm going to come to consultation in a moment. What I'm trying to ascertain is: are you aware of any responses from the states to the proposal in respect of the lottery? That is really what I'm asking.

Dr Studdert: We're aware of media—

Senator FARRELL: If the answer is no say no and I'll discontinue this form of questioning.

Dr Studdert: We can confirm that we're aware of the same media reports that you're aware of. As Mr Smith has indicated—

Senator FARRELL: Okay.

Senator SMITH: What media report is that, Senator Farrell?

Senator FARRELL: It was Mr Smith who raised the media reports.

Senator SMITH: Is it the one of 21 August, where the consultation period with states was extended?

Mr Smith: I'm speaking in general terms. I follow the media, and I watch the media in relation to my areas of responsibility. I am aware there has been media in relation to the lottery, including the views of state ministers. I can't speak to the specific articles or dates at this point.

Senator FARRELL: I certainly wasn't asking you to. Senator Smith might be.

Senator Smith interjecting—

Senator FARRELL: You're asking me?

Senator SMITH: Yes, I was asking you. The tradition is that when people are quoting from documents, particularly media reports, that the documents be circulated.

Senator FARRELL: Senator Smith, let's be clear: the reference to the public comments was made by Mr Smith. He said he was aware of public comments.

Senator SMITH: No, in your opening question you talked about 'media report'.

Senator FARRELL: Well, I defer to you.

CHAIR: If you are going to quote from an article, it would be handy to table it, but please continue, Senator Farrell.

Senator FARRELL: Thank you, Chair. I refer to two comments by state ministers who have come out in opposition. Are you aware that some state ministers have come out in opposition to the lottery?

Dr Studdert: Yes.

Senator FARRELL: Thank you. That's all I wanted; we could have saved 15 minutes. In response to question on notice No. 653, from the last estimates, we were told:

Discussions with states and territories, including the terms of their participation in a national lottery, should it proceed, will occur as the concept is further developed.

I think this is where you started to tell us about these conversations. Did the minister or his office ask the Office of Sport or the ASC to speak to any of the states at an agency or departmental level before he announced the lottery plan?

Ms Palmer: No.

Dr Studdert: No.

Senator FARRELL: There were no discussions prior to the announcement at any government level with any state or territory agency.

Ms Palmer: Not that I'm aware of.

Senator FARRELL: So the proposal came as a complete surprise to the states and territories.

Ms Palmer: I can't confirm that.

Senator FARRELL: Well, if they didn't know about it and you haven't—

Ms Palmer: I'm not sure. I said I'm not aware of it.

Senator FARRELL: At the time the minister came out very strongly and said, 'The Commonwealth can easily legislate for an online lottery.' Do you recall the minister saying that?

Ms Palmer: No, I can't.

Senator FARRELL: Mr Smith, do you recall the minister saying that?

Mr Smith: I don't recall the specific statement, but I'll take your word that he said that.

Senator FARRELL: I beg your pardon?

Mr Smith: I don't recall the specific statement. If you have that then I will accept that.

Senator FARRELL: But you're happy accept to accept that that's a correct statement by him. At the last estimates, I asked about the legal advice the government might have had to give the minister such confidence in the Commonwealth's ability to legislate and whether any advice had been provided, either formally, of a written nature; or a verbal nature. Then in question on notice No. 655, from last estimates, we got this response:

The Department is unable to disclose the nature of any advice received by the Department or the Australian Sports Commission as it is covered by legal professional privilege

Is that still your position?

Dr Studdert: Yes.

Senator FARRELL: Why can't you tell us—not revealing the information—whether that advice was given in a written form or a verbal form? Surely that doesn't breach legal—

Mr Smith: I can say it was given in both forms.

Senator FARRELL: At last estimates we also talked about modelling conducted on the revenue potential of a lottery structured in the way that Minister Hunt has described. Mr Howes mentioned at the time that more robust modelling was needed. An answer to question on notice No. 657 from the last estimates, provided an update and suggested some more robust market analysis has been completed. Are you able to share with us any of the findings of that modelling? Can it be tabled to the committee?

Dr Studdert: I will ask Ms Palmer to answer that because modelling was done by ASC.

Ms Palmer: My response is that because of the market sensitivities it wouldn't be prudent for us to provide that detailed information in public. We are willing to provide advice in camera and meet with you to provide further information, however.

Senator FARRELL: I just want to be clear—thank you for that, and I will take up that offer. Will that extend to other members of the committee if they so wish?

Ms Palmer: Can I take that on notice so that I can confirm that?

Senator FARRELL: Yes. It certainly relates to me. Senator Smith's indicated—and he's a very trustworthy fellow, let me tell you, so he won't certainly be leaking any information to media organisations, I'm sure.

Senator SMITH: No.

Senator FARRELL: And nor will I, by the way.

Ms Palmer: Thank you.

Senator FARRELL: I just want to be clear. Mr Howes said there was going to be more-robust modelling, and that has been done.

Ms Palmer: I can ask Mr Howells to answer that question for you, if you'd like.

Senator FARRELL: That would be excellent.

Mr Howes: Yes, we have done a range of different modelling to cover a number of scenarios.

Senator FARRELL: Thank you. You would propose that we deal with that in camera. Are you suggesting tonight or at a more—

Ms Palmer: At your convenience.

Senator FARRELL: Thank you. Given that Senator Smith might also like to attend, we might do it—we're back in two weeks—in two weeks time, if that would suit. Who would give us that? Would it be you, Mr Howes?

Mr Howes: Yes, we can provide that.

Senator FARRELL: Thank you for that. I appreciate your direct answers, too, Mr Howes. The answer to question on notice No. 657, also says that the sample size has been tripled for this more robust modelling. That's a question we might deal with in camera?

Mr Howes: Yes.

Senator FARRELL: I also would have asked about the sample size of this more recent modelling exercise and also the original less robust research. So we'll deal with that in camera.

The answer to that same question on notice refers to a 'market-sounding exercise to test some of the assumptions in the modelling, which will assist in the policy proposal development'. Mr Hunt has said that all of the details of the lottery will only be settled through the consultation process. Is the market-sounding exercise necessary because the modelling already completed relies on too many assumptions? Is that a question you would prefer to answer in camera?

Mr Howes: I think it's better to cover part of it in camera. The market-sounding exercise was needed because there were a number of different scenarios that were at play. An example is whether it's sport, sport-arts—

Senator FARRELL: And you modelled all of those?

Mr Howes: We did look at those things, yes.

Ms Beauchamp: Could I just comment? I may need to take this on notice, but I would much prefer, while the government is in consideration of the sports plan and the feasibility around revenue options, to take government and the minister through this before we provide any further information in camera. I will take advice from the minister about provision of that modelling information.

Senator FARRELL: Does that mean the offer to Senator Smith and I to receive in camera information the week after next has been withdrawn?

Ms Beauchamp: I just want to make sure that we are briefing the government and the minister first before we offer that, yes. So it might be around timing.

Senator FARRELL: So you're not withdrawing the offer; you're simply—

Ms Beauchamp: I am taking it on notice and we will provide you with further advice on that.

Senator FARRELL: I want to be clear: is the offer to provide the in camera information being withdrawn?

Ms Beauchamp: At this stage, I would suggest yes, because I really think that we should be advising the minister and government before providing any modelling advice externally.

Senator SMITH: Bad luck, Senator; we don't get to find out. We'll be back in February next year.

Senator FARRELL: We may not.

Senator SMITH: I'm an optimist; we'll be back in February next year.

Senator FARRELL: Well, in that case, if I'm not going to be provided with the information, can I go back to the questions that I was happy to discuss in camera and see whether I can get a response here tonight? Can you tell us about the sample size of this more recent modelling exercise and also the less robust research?

Mr Howes: I will take that on notice.

Senator FARRELL: I don't think my next question goes to anything confidential. Is there any reason that the more robust modelling and this market-sounding exercise could not have been done earlier?

Dr Studdert: Senator, I think we moved in an appropriate time line following the minister's announcement and request to us to progress work.

Senator FARRELL: So the answer is no?

Dr Studdert: When you say 'earlier', we couldn't have pre-empted that. We started work immediately after—

Senator FARRELL: The minister obviously knew that he wanted a lottery. By all accounts, he has not discussed that with any of his state or territory colleagues, because it has come as a complete to them.

Dr Studdert: As Mr Smith mentioned, it was discussed at the sports ministers meeting in August.

Senator FARRELL: But that was well after the minister announced his lottery plan, surely?

Dr Studdert: Yes.

Senator FARRELL: It's not a trick question. Don't think that I'm trying to trick you here. All I'm saying is that it's possible that it could have been done at an earlier stage, before the minister came out with, what now looks like, something of a thought bubble.

Dr Studdert: That sounds like an opinion you are asking for, and that's not our place to give you such.

Senator FARRELL: All right. If all or some of the details of the proposed lottery had already been determined through consultation with the states and territories, and other relevant stakeholders, would that have made the modelling process more efficient and useful, Mr Howes?

Dr Studdert: Again, I think you're asking for an opinion that it's not our place to provide.

Senator FARRELL: I was asking Mr Howes and he has been very forthcoming with his answers, and honest.

Mr Howes: Can you repeat the question?

Senator FARRELL: Sure. If all or some of the details of the proposed lottery had already been determined through consultation with the states and territories and other relevant stakeholders, would that have made the modelling process more efficient and more useful?

Mr Howes: This is an opinion. I'm not sure, because there were so many different possibilities and scenarios at play.

Senator FARRELL: Thank you. Would you say it would have made the case for the lottery more robust if the consultation had taken place, followed by the modelling, before any announcement?

Mr Howes: No, I think the modelling and analysis is perfectly robust.

Senator FARRELL: Earlier this month the Treasurer, Mr Morrison, confirmed the government was planning to take a cut of any state point-of-consumption taxes on online gambling and suggested the proceeds would be used for funding sport. I quote the Treasurer from the *Daily Telegraph* on 10 October, Senator Smith:

'Any and all proceeds would be used to fund sport,' he said.

'If the states want the Commonwealth to provide a national solution ... we would want it to address funding requirements for national sports, rather than consider a national lottery.'

Minister, perhaps you could respond to this one. There appear to be two different approaches, the one by Minister Hunt, calling for a lottery, and the response by the Treasurer, that you're not going to consider a lottery, that you are going to consider a different consumption tax on online gambling. Which is it? Which of the two approaches is the government intending to proceed down? Mr Howes is obviously working very hard on some modelling for the lottery, but perhaps that's going to be a wasted exercise if the government now goes down the track of a point-of-consumption tax?

Senator Nash: I expect that would be a matter for the Treasurer. The government is still considering the lottery. I understand the minister said at the time that he would be exploring the option and that would entail looking at the feasibility around that.

Senator FARRELL: Yes, but the Treasurer was pretty clear. He is looking at an alternative and he says, 'rather than consider a national lottery'. So it would appear that he is not going down the track of a national lottery, and we've got Mr Howes spending all of his working hours doing modelling. Are we wasting our time on that modelling if the Treasurer has basically already determined that we're going to have a tax on online gambling to fund sport?

Senator Nash: That side of it would be a matter for the Treasurer, and, as I said, the government is considering the lottery. I don't think I can really add anything further than that.

Senator FARRELL: So, potentially, we are looking at two methods of funding here, one that the Treasurer suggests—a point-of-consumption tax—and the other one a lottery that the health minister is suggesting. Is that what you're telling us?

Senator Nash: I've just made my comments pretty clear. You've asked me the same thing and I've already answered that.

Senator FARRELL: Well, just so I understand, the answer is yes. Is that correct?

Senator Nash: The answer, as I said—the first question related to the Treasurer and the second comment I made was that the government was exploring—

Senator FARRELL: So, both of them are right. The Treasurer is going to fund—

Senator Nash: No. Don't try to draw me into some sort of comment you want me to make. I've answered your question three times, so I would refer you to the *Hansard* now.

Senator FARRELL: All right. Thank you. Has the ASC or the Office of Sport been asked to source any modelling for the latest idea by the Treasurer, or to do any preliminary work on it?

Dr Studdert: No, not from the Office of Sport or the department.

Ms Palmer: No.

Senator FARRELL: So the Treasurer is going down with this point of consumption tax on online gambling but he is not seeking any input from the Office of Sport or the ASC, is that correct?

Dr Studdert: That is correct.

Ms Beauchamp: That is correct.

Senator FARRELL: I've got some more questions on the National Sport Plan. I asked quite a few questions on notice because we ran out of time, as you might recall, last session. In answer to question on notice 907, was the appointment of a panel to review sports integrity under way as of 16 June? Could you please update us on where the appointment process has got to?

Mr Godkin: The minister made an announcement on 5 August which outlined the arrangements for the review of the Australian sports integrity arrangements, and the panel members were identified in that release.

Senator FARRELL: You don't happen to recall who they are, do you?

Mr Godkin: Yes, I do. The review is being chaired by James Wood. He is being assisted by former WADA director-general David Howman and former chief steward Racing New South Wales Mr Ray Murrphy. They are also being supported by two adjunct panel members, Dr Annabelle Bennett AOSC, and Ms Jo Setright, nominated by the sports movement.

Senator FARRELL: Did you say the 'sports movement'?

Mr Godkin: Yes, that's right.

Senator FARRELL: What's the sports movement?

Mr Godkin: COMPPS, the Coalition of Major Professional and Participation Sports, nominated Ms Jo Setright. The Australian Paralympic Committee, Australian Olympic Committee and the Commonwealth Games Australia nominated Dr Bennett.

Senator FARRELL: Have they met?

Mr Godkin: Yes.

Senator FARRELL: Did the department or the commission or ASADA provide any recommendations to the minister or his office about the appointment? Obviously some of them came from outside groups. But did the department, ASC or ASADA provide any recommendations for the rest of them?

Mr Godkin: We provided a number of options of well-credentialed individuals, in our view, for consideration for appointment to the panel, yes.

Senator FARRELL: Were any or all of those recommendations accepted?

Mr Godkin: The panel members appointed were amongst those that were recommended, yes.

Senator FARRELL: So some of your appointments were accepted. Were any of them rejected?

Mr Godkin: No, but there were a number of different names that were under consideration but we ended up with the panel size we have now and that was the recommendation.

Senator FARRELL: Are there five on the panel?

Mr Godkin: There are three core members and two adjunct members, yes.

Senator FARRELL: It was suggested at one stage that a panel or committee would be tasked with pulling together the National Sports Plan but the answer to question on notice 907 says, 'There was no independent panel overseeing the National Sports Plan.' So if that's the case, could you explain how the National Sports Plan is going to be developed? Will it be the ASC doing it, the Office of Sport, the minister's adviser, the minister himself, or a combination of all of those?

Dr Studdert: We've established a small team in the department with staff from the ASC working on loan from the ASC with us but we are liaising very closely and carefully with the ASC.

Dr Studdert: We've established a small team in the department, with staff from the ASC working on loan from the ASC with us but liaising very closely and carefully with the ASC, and there's been an extensive consultation process which we would be happy to give you some details of. My colleague Ms Smith can do that.

Senator FARRELL: You're happy to give some details?

Dr Studdert: Of the consultation process, yes.

Senator FARRELL: Oh, excellent. Fire away—another Smith? Lots of Smiths in this room! Must be a common name!

Ms N Smith: Yes.

Senator FARRELL: Are there any Smiths at the back there?

Ms N Smith: We had a consultation process open for the public and the sport sector from 22 May to 31 July this year. We conducted 14 forums. We had nine sports sector forums, in all eight capital cities. We did three national sporting organisation forums, in Brisbane, Sydney and Melbourne. We did one preventative health forum for preventative health and education stakeholders in Melbourne. We did one sports leaders forum at Parliament House.

We had approximately 500 people attend those forums. In addition, we had 433 submissions that were received and—

Senator FARRELL: Sorry, what was that figure?

Ms N Smith: 433. We also had a survey on community perceptions on sport, and we had 3,541 people respond to that.

Senator FARRELL: How did you do that survey?

Ms N Smith: The survey was on a website and people were able to go on and complete the survey online.

Senator FARRELL: How did they become aware that they could do that survey? How did you communicate with them?

Ms N Smith: We had that on the ASC website, and we communicated that in the forums as well.

Senator FARRELL: I mean, that's a high number who've responded; would you not say?

Ms N Smith: Yes. We were pleased that people took the time to respond.

Senator FARRELL: Those 433 submissions—are you able to provide or table those submissions?

Ms N Smith: The actual submissions themselves?

Senator FARRELL: Yes.

Ms N Smith: I'm not sure that they are for public display.

Ms Beauchamp: We can take that on notice, in consultation with those that put in the submission, whether we can make them public.

Senator FARRELL: Right, so if they are happy to have their—

Ms Beauchamp: I'll take it on notice.

Senator FARRELL: If, having taken it on notice, you come back and say you're happy to provide that information, what would be the best way to do that? Would you put it up on your website?

Dr Studdert: If the respondents agree for them to be publicly released, we'd be happy to put them up on the website. Could I just add to my previous answer about the mechanism for developing the sports plan—we do have a steering committee that's been established with representation from the Australian Sports Commission, the Department of Health and PM&C, and the states are represented by one of their officials.

Senator FARRELL: All the states have a representative?

Dr Studdert: No, just one official nominated by the states to participate.

Senator FARRELL: Okay. And who is that person?

Dr Studdert: Phil Hamdorf, from New South Wales.

Mr Smith: Just to clarify, Phil Hamdorf is there to provide a state perspective, not necessarily elected by the states to represent all the states.

Dr Studdert: My apologies.

Senator FARRELL: Was he elected by the states?

Mr Smith: No. He's there to provide a state perspective. All the states know that he had been invited to do that, and they're comfortable with that. As a New South Wales person, he isn't representing WA, for example.

Senator SMITH: Thank you for that.

Senator FARRELL: Yes—it's just a bit unusual, though. Not to make too fine a point of it, he comes from a Liberal state, and you're saying all the other states, the Labor states, were comfortable with his appointment?

Mr Smith: Dr Hamdorf is the current chair of the senior officials group that reports to sports ministers, so it was in that capacity that he was invited.

Senator FARRELL: Oh, I see. So the minister invited him to join the group; the states didn't nominate him.

Dr Studdert: No; we formed the committee.

Senator FARRELL: The department?

Dr Studdert: Yes.

Senator FARRELL: And it was your choice to invite Mr Hamdorf?

Dr Studdert: Well, as Jaye said, it seemed appropriate, as the chair, that he was invited and the other states—

Senator FARRELL: Look, I'm not querying it; I'm just a bit surprised the New South Wales person was the person nominated. But, you know, if that's the case, fine. This steering group, how many people are on it?

Mr Smith: Four.

Senator FARRELL: Right. So each of those groups that you mentioned has one representative on the steering group?

Mr Smith: Yes.

Senator FARRELL: Steering committee is it?

Mr Smith: Steering committee, yes.

Senator FARRELL: Does it have a special name, the steering committee?

Mr Smith: The Steering Committee for the National Sports Plan.

Unidentified speaker: You've got to do better than that, come on!

Dr Studdert: It must have been devised after a long estimates hearing.

Ms Beauchamp: National sports plan steering committee.

Mr Smith: It could be that too.

Senator SMITH: Does it have an acronym?

Mr Smith: No, it doesn't. We refer to it as the 'steering committee'.

Senator FARRELL: I'm hoping that after we finish at 11 o'clock they'll let you go home and not give you any further work to do tonight. How many meetings has this steering committee had?

Mr Smith: I would need to take the exact number on notice. It's three or four meetings so far.

Dr Studdert: Kate, is your memory better?

Ms Palmer: No, it's not.

Senator FARRELL: Are you on the committee?

Ms Palmer: I am, yes.

Senator FARRELL: So it's a pretty high-powered committee?

Dr Studdert: Extremely.

Senator FARRELL: Yes. What sort of progress are they making?

Dr Studdert: We've had an excellent response to the consultation, so there's a lot of material to get through. Generally, everyone is quite happy with the progress.

Senator FARRELL: What would you expect the steering committee to do? They've got the 433 submissions, the 3,000 or so public responses. Will they sift through that and try to discern some themes or some policies?

Dr Studdert: The steering committee will work with and get advice from the working team. I think their role is to ensure that those interpretations are an honest reflection of that, that it's coming together in a timely and—

Senator FARRELL: So all this steering committee will do is basically summarise the nature of the submissions and the public responses?

Dr Studdert: Do you want to speak to that?

Mr Smith: No, Senator. The consultations have been held against specific themes that the minister has identified and publicly stated that the sports plan will be built around. The consultations are built around those themes. There is a lot to get through. There is a working group, a project team, that works between the Sports Commission and the Office for Sport.

Senator FARRELL: This is an additional body? We've got the steering committee and we've got this other body as well, have we?

Mr Smith: It's not a body, Senator. There are people who are working on this as their job, to develop and to support the development of the minister's National Sports Plan. The steering committee is the governance structure that sits above that. The teams are working through the detail of the feedback from consultations with a view to providing advice to the minister around the four themes that he has identified. That is progressing very well.

Senator FARRELL: Is it the steering committee that is going to provide the advice, or is it this other working group? Can we identify the name?

Mr Smith: The department and the Sports Commission would provide the advice to the minister. The steering committee is the governance structure that is overseeing the work that's being done by the teams in the Sports Commission and the Office for Sport that are developing things like—

Senator FARRELL: So the role of the steering committee is simply to direct the various people and the departments as to what they should work on to develop the plan—is that a fair summary? Tell me if it's not.

Dr Studdert: It's an internal-to-government governance structure to track the work, to ensure, for me and the secretary and the minister, that it's progressing in a timely way and that it's on track, consistent with the themes and priorities that the minister has outlined.

Senator FARRELL: And is it?

Dr Studdert: As I said, yes; we are satisfied that it's progressing—

Senator FARRELL: Okay, so when do you think we will see the plan?

Dr Studdert: That will be a matter for the minister.

Senator FARRELL: Right. So you don't have any projected—

Dr Studdert: The minister has said it is being prepared for 2018.

Senator FARRELL: Okay. Go back a step. When do you think you will be in a position to advise the minister as a result of all your deliberations?

Dr Studdert: We're on track to provide advice to the minister, consistent with his commitment to develop and release a National Sports Plan in 2018.

Senator FARRELL: So by the end of the year you will have done all your deliberations and be in a position to—

Dr Studdert: We're certainly hoping to have a solid draft, yes.

Senator FARRELL: Do you think it'll be earlier than that or is that about the time frame?

Dr Studdert: We'll be working towards a solid draft—

Senator FARRELL: I'm not going to hold you to it. I'm just trying to get some idea. There's a great deal of interest—as we know, there are 433 submissions and over 3,000 people.

Dr Studdert: Yes, it's a lot of work.

Senator FARRELL: So a lot of people have an interest in it and taken quite a bit of effort to get involved. So they'll be very—

Dr Studdert: Absolutely, and we're very mindful of that, and that's why we're putting a lot of effort into ensuring it's a solid piece of work.

Senator FARRELL: I'm sure you are. Will the people who have made submissions get any feedback before you give your final report to the minister?

Dr Studdert: No.

Senator FARRELL: I understand the operations of the AIS are being considered along with those of the other institutes as part of a separate national institute network review. Can you give us an update on that?

Ms Palmer: Yes, I can. The time line for a report to CASRO is 28 February 2018. The new director of the AIS, Peter Conde, commenced on Monday, and it's now his responsibility to have carriage of that work. But, as I reported at the last Senate estimates, the work is very collaborative and positive and I see it heading in the right direction.

Senator FARRELL: Do you expect to meet that 28 February time line?

Ms Palmer: We will definitely that deadline.

Senator FARRELL: Just out of interest, is Mr Conde related to Mr John Conde, the head of the Remuneration Tribunal?

Ms Palmer: I believe so.

Senator FARRELL: Are they brothers or—

Ms Palmer: I'm not sure, but, no, not brothers.

Senator FARRELL: They're not brothers?

Ms Palmer: I know they're not brothers, but I'm not sure of the relationship.

Senator FARRELL: Do you say that based on the age differential?

Ms Palmer: No, just advice.

Senator FARRELL: It's just that when I'm wearing another hat that I wear I deal with the other Mr Conde—that's the only reason I asked. Are you okay, Minister—keeping that seat warm?

Senator Nash: Absolutely, thank you for your concern, Senator. You are too kind. I've always said you were such a nice senator.

Senator FARRELL: You have always said that, and I've always appreciated it.

Senator Nash: I'm glad to hear that.

Senator FARRELL: And the ASC will not be looked at as part of the National Sport Plan process?

Ms Palmer: Could you clarify what you mean by 'looked at'?

Senator FARRELL: As we've discussed, there's examination of the AIS as part of this other review. Is there any review going on into the ASC?

Ms Palmer: Coming in as the new CEO in February, one of my major tasks was to work on the strategy for the organisation going forward, and certainly we've been working with the department closely on that, and that will be carried forward through the National Sport Plan also.

Senator FARRELL: Is there any reason why the expert panel couldn't have looked at the ASC as part of their deliberations?

Ms Palmer: Elements of the strategy are as part of the group, so the Australian Sports Commission board have provided their input into the process as well, and this steering committee will consider those elements as part of the process.

Senator FARRELL: So to some degree the ASC is a subject of the review?

Ms Palmer: Yes, definitely.

Senator FARRELL: Thank you. In the last questions on notice, the answer to question on notice 908 mentioned one consultation session in each capital city to give state and territory sport and recreation agencies an opportunity to provide input. You mentioned that in your summary, Ms Smith, did you not?

Ms N Smith: Yes, there was a consultation in each state and territory.

Senator FARRELL: Does the Office for Sport and the ASC regularly engage with state and territory officers and agencies?

Ms Palmer: The Australian Sports Commission does regularly. In actual fact, we meet as regularly as possible—formally through the CASRO process but also informally.

Senator FARRELL: How often would you do that?

Ms Palmer: Again, having only been in the position since February, I have made an effort to now meet with every head of department myself and visit each of them to understand their jurisdiction and to develop a relationship.

Senator FARRELL: Very good.

Ms Palmer: I have one to go before the end of the year.

Senator FARRELL: Which one?

Ms Palmer: Northern Territory.

Senator FARRELL: Good luck. What about the Office for Sport?

Mr Smith: Yes; we have regular contact with states and territories through the same CASRO processes that Ms Palmer was talking about.

Senator FARRELL: Do you do it together?

Mr Smith: We're both members.

Senator FARRELL: Are you both at the same meetings and consultation and so forth?

Ms Palmer: In some meetings we're together and some separately. The Australian Sports Commission works on some projects with the departments, which means we necessarily meet with them separately.

Senator FARRELL: Last month the department or spokesman told the ABC that FIFA and FFA governance discussions will be given consideration in deciding whether an additional \$4 million would be provided to the FFA's 2023 Women's World Cup bid. Can somebody tell me: what exactly are the criteria for the additional \$4 million to be provided?

Mr Smith: It relates to FFA's capacity to deliver a bid, the prospects of that bid's success, as well as satisfaction in relation to the bidding process itself, in terms of transparency and integrity.

Senator FARRELL: So capacity to deliver, transparency—what was the final one?

Mr Smith: The general prospects of the bid: is it a bid worth pursuing?

Senator FARRELL: Yes, we didn't do too well with the World Cup, did we?

Mr Smith: We didn't.

Senator FARRELL: You can comment.

Dr Studdert: It would appear not, no.

Senator FARRELL: No, we did not, no. Has the FFA been told in clear terms that those are the criteria for the remaining \$4 million?

Mr Smith: Yes.

Senator FARRELL: When was that?

Mr Smith: At the time at which the initial amount of funding—the initial \$1 million—was made available, it was made clear to them. I think that was in the budget context, I believe; I'd have to check the dates. It was at the time that the original money was made available—that the subsequent money would be subject to those.

Senator FARRELL: Was that in writing?

Mr Smith: Yes, I imagine so. I'd have to double-check the exact details.

Senator FARRELL: Is it possible to get a copy of that letter?

Mr Smith: I'd have to take that on notice.

Senator FARRELL: In the Prime Minister's media release on the funding, he noted the following things, by way of indication as to why the Australian government would support that 2023 bid: the success of the Matildas; the growing profile of women's sport in Australia; that hosting the Women's World Cup would inspire girls and women to engage in sport for fun and health; the economic benefits of hosting a FIFA event, with televised matches, playing to a global audience of more than 720 million, boosting domestic and international tourism and creating jobs. Do you recall him saying that?

Mr Smith: In general terms.

Senator FARRELL: Given those great reasons to support Australia's bid, has the minister asked the Office for Sport or the ASC to provide any support to the FFA to ensure it will be able to access the additional \$4 million of funding and put forward the best possible bid?

Mr Smith: No.

Senator FARRELL: My next question relates to a different topic, and I freely accept that it's not something that's being coordinated in the sports portfolio, but I wanted to quickly ask about the \$30 million that Minister Fifield is planning to give to Fox Sport. Has the Office of Sport or the ASC provided any advice to Minister Fifield about that or to Minister Hunt through to Minister Fifield?

Dr Studdert: We're all shaking our heads. I believe not.

Mr Smith: To clarify, you asked about money provided to the Office of Sport?

Senator FARRELL: No, no.

Mr Smith: Sorry, I misheard.

Senator FARRELL: I appreciate it's very late and you've had a very long day. I don't want to hold you here any longer than I have to.

Dr Studdert: He's getting a bit excited.

Senator FARRELL: What's getting exciting?

Dr Studdert: The \$30 million.

Senator FARRELL: Oh, no, no, it wasn't given to sport.

Mr Smith: That's why I was looking confused.

Senator FARRELL: I was asking about Fox Sport—television. In fact, now that I think about it, that \$30 million would have been more than half the money that the government has cut from sport. So it would have been very handy, but, no, he's given it to Fox Sport. Minister Fifield allegedly decided to give them \$30 million to improve the coverage of women's sport. It's had a fair bit of coverage. Certainly, a lot of questions have been asked in question time about it.

My question was: has the Office of Sport or the ASC been asked to provide any advice either to Minister Hunt to give to Minister Fifield or to Minister Fifield directly?

Senator Nash: It's really a question for Minister Fifield, wouldn't you think, Senator?

Senator FARRELL: I did predicate my question by saying that I appreciated it was in Senator Fifield's—

Dr Studdert: So the answer from us is 'No'.

Senator FARRELL: To be honest, Minister, I don't think it's an unfair question—

Senator Nash: I'm trying to assist you to get a fulsome answer.

Senator FARRELL: You're always trying to assist me. I have a very fulsome answer. It's the one, I have to say, I expected but I just wanted to confirm that.

Senator Nash: Good, excellent.

Senator FARRELL: I suspect if you had been advised you might have cautioned against it. This is probably a question for an accountant in the audience. The ASC file list for January to June 2017 includes a file under the heading of 'Property management/planning' and it's titled 'AIS Bruce campus office consolidation'. Is this office consolidation in any way related to a reduction in staff numbers or any sort of redeployment of staff to other duties or locations?

Ms Palmer: I might ask Fiona. I don't understand the question, Senator. Could you just repeat it?

Senator FARRELL: The ASC file list for January to June 2017 includes a file under the heading 'Property management/planning'.

Ms Palmer: Yes.

Senator FARRELL: Which is titled 'AIS Bruce campus office consolidation'. Is this office consolidation in any way related to the reduction in staff numbers or any sort of redeployment of staff to other duties or locations?

Ms Palmer: There are no plans for that to occur, no.

Senator FARRELL: Are there any plans to redeploy, relocate or otherwise move staff away from the AIS campus?

Ms Palmer: No, not at present.

Senator FARRELL: Are there any other plans relating to the commission and the deployment or location of any of its staff other than at the AIS?

Ms Palmer: We have staff in a range of locations. We have offices in four states—in Victoria, New South Wales, South Australia and Queensland. We also have staff at the ETC, our AIS European Training Centre, and we have staff regularly working with sport and imbedded in sport around the country and travelling globally with teams.

Senator FARRELL: You may want to take this question on notice. Could you explain what parts of the AIS facilities are on state or Commonwealth-held Crown land, what is owned and what is leased from the ACT government?

Ms Palmer: I can take that on notice.

Senator FARRELL: Have there been any approaches, unsolicited or otherwise, to the AIS, the ACT government or the federal government to buy, lease or redevelop any AIS facilities, or any land owned or leased by the AIS?

Ms Palmer: No, there haven't.

Senator FARRELL: I'd like to ask some questions about a couple of former funding programs. These programs are not current and were moved out of the sports portfolio and into the Department of Prime Minister and Cabinet. If you need to take them on notice, please do so. Can you tell me exactly when the Indigenous Sport and Active Recreation Program and Elite Indigenous Travel and Accommodation Assistance Program were moved to the Department of Prime Minister and Cabinet?

Ms Palmer: I would need to take that on notice.

Senator FARRELL: Could you also tell me exactly when the last grant under each of those programs was provided?

Ms Palmer: I do know the Elite Indigenous Travel and Accommodation Assistance Program ceased this year. The last grant was provided, I think, on 30 June.

Senator FARRELL: Would that have been June this year?

Ms Palmer: It was 30 June this year, yes.

Senator FARRELL: And did you say you knew the other one?

Ms Palmer: No, I don't, I'm sorry.

Senator FARRELL: Can you find that out for me?

Ms Palmer: I can find that out, yes.

Senator FARRELL: Can you please tell me how much in total was provided through each of those programs prior to the 2013 election?

Ms Palmer: I'd have to take that on notice as well.

Senator FARRELL: Thank you. Could you also please tell me how much has been provided under each of those programs since 2013 election?

Ms Palmer: Yes.

Senator FARRELL: Last estimates I asked about the intention to extend the Sporting Schools program to years 7 and 8 and focus on girls. Most of those questions were on notice and some responses have been provided, but the responses haven't really answered my questions. So I'll ask them again, if you don't mind. The budget papers show \$40 million for the program in 2017-18 and about \$20 million in 2018-19. The 2017-18 program will receive about the same amount of funding it had in the previous two years, and the 2018-19 one will receive about half that amount. Is that correct?

Mr Howes: It's because it runs until December 2018.

Senator FARRELL: So it's half the time.

Mr Howes: It's half the financial year.

Senator FARRELL: So, in fact, the amounts of funding are the same if you look at them on a yearly basis.

Mr Howes: Correct, yes.

Senator FARRELL: In my question on notice 918(a) I said I'd like you to expand upon that question. How exactly are you going to extend the program to years 7 and 8 and focus on girls? Will it simply be a matter of opening up the program to those year levels and promoting them into girls' schools—or what will be done?

Mr Howes: Prior to the last extension of the program, we ran a pilot program looking at years 7 and 8. On the basis of the lessons from that pilot program we targeted schools for involvement as part of the extension.

Senator FARRELL: So it will now be available to years 7 and 8.

Mr Howes: Yes, schools that meet the criteria that have been set for that extension.

Senator FARRELL: Yes, but with a particular focus on girls.

Mr Howes: Yes.

Senator FARRELL: Given that there's no more funding than has previously been available, surely that means there's less money to go around in the rest of the program?

Mr Howes: We've adjusted the targets, adjusted the KPIs.

Senator FARRELL: But what I'm saying is correct, isn't it? There's less money to go around?

Mr Howes: Well, no. It's still the same amount of money to go around, but—

Senator FARRELL: If you take out the year 7s and 8s and look at the rest of the operation, then surely—if there's the same amount of money, you're doing more—

Mr Howes: Well, we're still funding schools.

Senator FARRELL: Yes, but surely there's less money to go around in the younger years?

Ms Palmer: I believe that we've actually exceeded our targets, so we've been able to manage to deliver the program at the same level.

Senator FARRELL: For the other years?

Ms Palmer: Yes.

Senator FARRELL: How was that done?

Ms Palmer: Prudent management.

Mr Howes: The grants are variable, so it depends on the level of activity.

Senator FARRELL: Thank you for your assistance. Now I have some questions for ASADA. Welcome, Mr Sharpe. How are you enjoying the job?

Mr Sharpe: It's a steep learning curve—first four weeks in.

Senator FARRELL: What have you learnt?

Mr Sharpe: It's a wonderful organisation and it's a great time to be in this position.

Senator FARRELL: Are there any challenges?

Mr Sharpe: There are a number of challenges, yes.

Senator FARRELL: Tell us about them.

Mr Sharpe: First of all, I think I'd just like to state that this is my first appearance before a committee, and in the interests of time I've prepared a written opening statement.

CHAIR: I should have invited you to make an opening statement, but thank you for tabling one.

Mr Sharpe: In the interests of time I'd seek the approval of the committee to table that.

CHAIR: You could read it into *Hansard*.

Senator FARRELL: Is there anything you'd particularly like to highlight in your opening statement that you think the committee would like to hear about?

Mr Sharpe: It just sets out my history and where I've come from after 30 years of policing but also the unique experience I bring to the table as an athlete, a coach and an administrator in national rugby league as part of my experience and appointment to this role.

Senator FARRELL: An ideal combination, you'd have to say.

Mr Sharpe: Thank you.

Senator FARRELL: I did ask you about challenges. What do you think your challenges are in the job?

Mr Sharpe: I think every job brings challenges. I think coming out of I guess the biggest anti-doping crisis in Australia's sporting history it was certainly a challenge to lead the agency into the next phase post that.

Senator FARRELL: Yes. What lessons do you think you've learnt from that previous period that you referred to?

Mr Sharpe: Well, I think sitting back from the outside, given that I've been in this role for only four weeks, it's been a great opportunity, given that I have an understanding of sport and athletes, to come to this position and leverage the platform of where we landed post that period and to look at the 2015 changes to the WADA code, to look at our focus and to look at the focus of the organisation and our operating strategy and model moving forward.

Senator FARRELL: In May Ms Lind told us that the vast majority of the almost \$1.5 million announced in the last budget for anti-doping measures in the lead-up to the Commonwealth Games had already been spent. In late August there was announcement of a high-integrity anti-doping partnership to support clean athletes and promote and protect the legitimacy and credibility of the games. That announcement referenced a number of actions, including a pre-games anti-doping task force, intelligence sharing, testing of athletes prior to their arrival at the games and, for the first time, a long-term storage of every single sample collected during the games for future reanalysis. How are those activities of the partnership being funded?

Mr Sharpe: Those activities have been funded by government. The activities so far involved setting up a task force made up of 14 different partners across the globe who have an interest in the Commonwealth Games and a fair Commonwealth Games, and that's to identify and target our test distribution plans, of which funding was for 375 tests of international athletes, to which we have done over 200 already, and are well on track, and as well for 375 tests of Australian athletes.

Senator FARRELL: Is it on a cost recovery basis?

Mr Sharpe: That is funded by government, certainly as direct funding to the organisation.

Ms Lind: The in-games component of that program—that's what happens once the village opens, from 25 March—is on a cost recovery; that's on a contract basis between ourselves and GOLDOC. The government appropriation of the \$1.5 million, which we spoke about last time, from the last budget pays for the pre-games testing, both for our surge testing in relation to the Australian team and the offshore testing of foreign athletes.

Senator FARRELL: The cost recovery really only comes in once the games commence?

Ms Lind: That's right, and that's on a contract between us and GOLDOC.

Senator FARRELL: There's obviously a contract—is it between GOLDOC and ASADA?

Mr Sharpe: That's correct. There's a contract being negotiated at the moment for the delivery of the services.

Senator FARRELL: It's not finalised?

Mr Sharpe: It's close to finalisation. At the moment it's just pending some minor issues around making sure the standard for the principles of delivery of that program are at the highest level.

Senator FARRELL: That's exactly what we'd want, isn't it?

Mr Sharpe: Exactly.

Senator FARRELL: Is that contract going to be publicly available?

Mr Sharpe: That would be a contract between us and GOLDOC. That would be a matter I'd have to take on advice.

Senator FARRELL: Could you let me know?

Mr Sharpe: I can.

Senator FARRELL: Thank you. There are a couple of files listed in the ASADA file list for January to June 2017 that I'd like to ask about. Under the heading 'Property Management' there is a file titled 'Planning Post September 2015 Lease Options'. Could you talk us through that, and are there any issues with the current lease arrangements or any plans or requirements on the part of ASADA's operations to move?

Mr Sharpe: Our lease currently has expired and we're on a month-to-month lease where we are based. Negotiations are continuing at the moment through the department, involving advice from us around the further extension of that contract.

Senator FARRELL: Do you expect you'll stay where you are?

Mr Sharpe: At this point the plan would be to stay there in the immediate future, yes.

Senator FARRELL: Under the heading 'Strategic Management' there is a file titled 'Policy, National Sports Plan and Related Submissions'. The National Sports Plan submission is fairly self-explanatory. Is that a submission you'd be able to table?

Mr Sharpe: I can advise that ASADA did not progress with a submission to the Sports Plan. What instead it did was chose to table a submission to the Wood integrity review.

Senator FARRELL: Thank you. That clarifies that. My last question is to the secretary. You said you were going to review the release of the information we discussed earlier. When do you think I will be advised about that?

Ms Beauchamp: I will consult with Minister Hunt and provide advice as soon as possible.

Senator FARRELL: Thank you.

CHAIR: It being after 11 pm, that concludes examination of the Health portfolio. I sincerely thank the minister and officers for their attendance, as well as Hansard,

Broadcasting and the secretarial staff. Senators are reminded that written questions on notice should be provided to the secretariat by close of business on Friday, 3 November 2017.

Committee adjourned at 23:00